tMDS 3.0 Vendor Questions and Answers 1 – 13 Consolidated

December 10, 2012

ID	Topic	Question	Answer
20121210-001	A - Policy	I am trying to help a facility troubleshoot an issue where a resident doesn't trigger for Prevalence of Falls on their MDS 3.0 Resident Level Quality Measure Report as they think it should (Facility ID 35403). I used the report dates the facility gave me as 02/01/2012 to 07/31/2012 and the resident (for resident ID 21755645) doesn't trigger unless I run the same report using the default dates of 04/01/2012 and 09/30/2012. The only difference I can see is where the values for A0310A (for OBRA Assessments) fell in the range of qualifying RFAs for the default dates 04/01/2012 and 09/30/2012 while didn't between dates 02/01/2012 to 07/31/2012. The facility completed PPS only assessments within the report dates 02/01/2012 to 07/31/2012 where J1800 = 1. I looked at the QM Manual at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-QM-Users-Manual-V60.pdf and see on page 7 that the qualifying RFAs are: Qualifying RFAs A0310A = [01, 02, 03, 04, 05, 06] or A0310B = [01, 02, 03, 04, 05, 06] or A0310F = [10, 11] It seems like this measure is not calculating for the look-back scan when A0310B = [01, 02, 03, 04, 05, 06] and A0310A is not = [01, 02, 03, 04, 05, 06].	The resident that you wrote about had an admission date of 5/1/2012. Residents are classified as short-stay or long-stay depending upon the number of days they resided in the facility as of the report's ending date. Residents with 100 or fewer days are classified as short-stay, while residents with 101 or more days are classified as long-stay. This resident would have reached their 101st day on 8/9/2012. This means that when you ran the report ending 7/31/2012, they were still classified as short-stay and were therefore not included in the long-stay falls measure. When you ran the report ending on 9/30/2012, they would have been classified as long-stay and would therefore have been included in the measure. If you have questions about the details of how residents are classified as long- or short-stay, please refer to page 1 of the current QM User's Manual (version 6). Please let us know if you still have questions about this.
20111110-001	A - Policy	Will CMS release the planned formatting of the facility profile report? We want to have the correct columns and order of columns.	The Facility Characteristics Report has been released.
20111110-002	A -	The second digit of the AI code of 'A' seems to say that we	Clarification regarding how to bill an End-of-Therapy

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	Policy	have to use previous MDS that had the score for the continuation after the OTR. There are several questions involved. If the EOT date was in the grace period, which assessment does it refer to? Based on the RAI manual, it refers to the 30-day assessment, but days 61 and 62 would have already been covered by the 60-day assessment. Is there corrected wording for that? What is the scenario that should be used in this case?	OMRA reporting Resumption. Answer: In cases where a facility completes an End-of-Therapy (EOT) OMRA reporting a Resumption of Therapy (EOT-R), the facility should bill the days covered by that assessment in the following manner. The AI code chosen for this assessment will have a second character of A, B, or C as these are the only second characters related to an EOT OMRA reporting resumption. The first character of the AI code will be chosen based on if this assessment is combined with a scheduled PPS assessment or completed as a stand-alone assessment. This AI code is then attached to the three character non-therapy RUG code, to form the five character HIPPS code, determined by the information coded on the assessment for those days when the resident did not receive therapy and would be attached to the three character therapy RUG code found on the most recent PPS assessment used for payment which included a therapy RUG beginning the day that therapy resumes. Consider the following example. A resident, Mr. P, is admitted on 10/01/11. The ARD of the 5- day assessment for Mr. P is set for 10/07/11 (Day 7) and the RUG assigned to Mr. P is RVB. The ARD of the 14-day assessment is set for 10/14/11 (Day 14) and the RUG assigned to Mr. P is again RVB. Due to an acute illness, Mr. P is unable to receive therapy services from 10/18/11 through 10/21/11, but is expected to resume therapy on 10/22/11 under the same therapy regimen. The facility completes an EOT for Mr. P with an ARD of 10/20/11 and reports that the resumption of therapy will occur on 10/22/11. The EOT OMRA assigns Mr. P a non-therapy RUG of CE2. Mr. P is discharged from the facility on 10/28/11. In the case described above, assuming no intervening assessments were necessary, the facility would bill in the following manner. Days 1-14 would be billed under HIPPS code RVB10. Days 15-17 would be billed under HIPPS code RVB20. Days 18-21 would be billed under HIPPS code CE20A. Days 22-27 would be billed under HIPPS code RVB0A.
20111110-003	A -	Will the printable item sets ever be backward compatible or	They are based on the target date of ARD, Discharge Date

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	Policy	are these simply based on the target date?	or Entry Date.
20110126-001	A - Policy	It came to our attention that the specs had a change that went out this week. Vendors were only made aware of this via the State of Texas. Is it possible to send out updates when specs change, via QTSO or CMS Updates?	You should be checking the CMS and QTSO websites for updates. The CMS Technical Website begins with a "What's New" section. There may be tools available to you outside the CMS structure that you may use should you choose. However, CMS can't guarantee accuracy of these tools.
20110126-002	A - Policy	Will anything be done to verify that the therapy dates are correct when flagging A0310C as an SOT or EOT OMRA? For example 1- that there are start dates if an SOT OMRA is specified 2- that there is at least one end date and that all therapies have end dates and not dashes if an EOT OMRA is specified. 3- for an SOT OMRA that the earliest therapy start date is no more than 7 days prior to the ARD What happens if this information is incorrect and the assessment is accepted as is? Note that the AI code generated uses A0310C and does not verify the dates. This makes the logic for billing unusable.	CMS will consider edits to the OMRAs. However, due to midnight rule, leaves of absences, and other issues, some edits would be too firm and may prevent a provider from completing and submitting an accurate and required assessment. The provider is responsible for ensuring that assessment data is accurate. When a provider enters inaccurate information, the provider must determine what should be done to rectify the assessment. In some instances a significant correction assessment should be completed, a modification of the existing assessment or an inactivation of the assessment. CMS specifications for the MDS 3.0 meet OBRA and SNF PPS assessment requirements; they don't meet billing needs. A provider must ensure that claims are accurate. For example, if a provider completes a late SNF PPS assessment, the provider must follow the late assessment policy, which is bill default for the appropriate number of days. Keep in mind that assignment of a RUG-IV/HIPPS does not mean that SNF coverage requirements have been met – the provider must ensure all requirements are met, not the assessment tool.

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20110126-003 Part -1	A - Policy	**INTERPRETING THE SUB-REQ FIELD** With the implementation of MDS 3.0, our organization interpreted the SUB-REQ field to be the deciding factor on whether a record should be included in the EDT file. That interpretation was based on the actual MDS description of the SUB-REQ field which states: 1. Neither federal nor state required submission, 2. State but not federal required submission 3. Federal required submission. Our software was designed so that if a MDS has a SUB-REQ = 2 or 3, then the record is included in the EDT file and is transmitted to CMS. If the SUB-REQ field = 1, then the MDS does not get included in the EDT file. We do not allow any other way to remove records from the EDT file. **ACTUAL DEFINITION** The actual RAI manual definition of the SUB-REQ field differs from the MDS descriptions. That definition states the value is based on whether the resident is in a Medicare or Medicaid certified bed. All of our beds are certified, so based on the RAI manual, all of our MDS's must have SUB-REQ = 3.	The requirement for SUB-REQ has not changed with MDS 3.0. With MDS 3.0 CMS created an item specific for the sub-req. The sub-req is determined by the type of unit the resident is on and which entities have the authority to collect the assessment data. It is not at all related to payment type. Page A-6, states: Code 1, when the unit the resident is on, is not Medicare or Medicaid certified unit AND the State does not have the authority to collect MDS information for residents on this unit Code 2, when the unit the resident is on, is not Medicare or Medicaid certified AND the state does have the authority to collect MDS information for residents on this unit Code 3, when the unit the resident is on is Medicare and/or Medicaid certified. CMS requires that assessments required to meet OBRA and/or SNF PPS requirements are submitted (sub-req 3) and when a State has the authority to collect but unit is not certified (sub-req 2). Thus, CMS specifications meet only these requirements. A provider may choose to complete an assessment for other purposes, such as HMO billing. However, if the provider completed item A0310 accurately, which they should,– A0310A = 99, A0310B = 99, A0310C = 0, and A0310F = 99, a CMS item set would not be generated. Thus this not an assessment to submit.
20110126-003 Part 2	A - Policy	**CONFLICT BETWEEN DEFINITION & MDS OPTIONS** Recently, this topic was also brought up on the MDS Central forum with the following explanation being used to describe how to process HMO MDS's that do not require transmission: If an HMO requires a RUG score based on an MDS assessment following the PPS schedule, create an MDS assessment and complete as you would if it were an actual MDS/PPS to attain a correct RUG score. Since these assessments are NOT reimbursable under the SNF PPS, they do not need to be submitted but retained in the facility's files for HMO review. If you do submit, it will still be accepted. The issue arises if the last MDS (HMO) submitted was a 14-	CMS is not responsible or capable of meeting all the possible needs of all providers and payers for non-OBRA and non-SNF PPS requirements. CMS would not be able to validate all possible payer source codes, possibly edits. Vendors are permitted (and encouraged) to add questions/items that are not part of the CMS item set, are not included in the submitted file in order to meet provider needs. How these needs are met are between the provider and the vendor, i.e., a business arrangement. CMS can suggest how these needs might be met but we can't require that these non-OBRA and non-SNF PPS needs be met.

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		day (e.g.), then the resident converts to a traditional Medicare, the real 5-day PPS/MDS submitted will get a sequential error, although non-fatal. What do you put in the A0410 field? Complete the HMO MDS exactly as if it were a PPS MDS. Since this MDS is not submitted and simply used as a tool for payment by the HMO, it doesn't matter what you answer A0410. If it concerns the facility why an MDS is not transmitted, either create a policy regarding HMO MDS or simply print/copy the HMO MDS and store w/ the medical record, then delete the HMO MDS from the history. Based on the comments above, it seems that other organization have interpreted that the SUB-REQ field does NOT drive the submission process and that we are not required to submit the Insurance MDS's that would have a SUB-REQ = 3. Can someone from CMS please clarify if the SUB-REQ field should be tied to the EDT transmission process or if the two processes stand alone?	A vendor may develop a separate set of specifications to meet these needs and allow the provider to choose which specifications to use for the resident. The vendor could 'add' to the CMS specifications, but then would need to develop items that are not part of the information submitted to CMS when the assessment is required by CMS. For example, additional items that may meet some of the provider needs are: - payer source, - payment system (which may be a RUG-III, RUG-IV, other case mix methodology, etc.), - assessment type/frequency – for example a payer may require assessments to be completed every 45 days The A0410 field should not be changed since this item is specific to the unit the resident is on. Changing A0410 leaves the provider vulnerable for not submitting assessments that are required for OBRA and/or SNF PPS. CMS does not require that the sub-req item be automatically tied to the transmission file.
20110126-004	A - Policy	With the clarification that MDS Assessment Reasons cannot be modified, we would like to discuss the following process that some states require and what should be done after the April 2011 have been made. ********** SOME STATES REQUIRE A MODIFICATION CORRECTION REQUEST OF THE DISCHARGE ASSESSMENT FROM 'RETURN ANTICIPATED' TO 'RETURN NOT ANTICIPATED' IN CERTAIN SITUATIONS. If the facility completed a Discharge Assessment - Return Anticipated (A0310F = 11) because the resident was expected to return to the facility within 30 days, and the facility learns later that the resident will not be returning to the facility; **another Discharge Assessment is not necessary**. However, the state may require a modification from "return anticipated" to "return not anticipated." The State RAI Coordinator can be contacted for clarification if your state	If a state needs to know when a resident doesn't return to a facility, they may not require a provider to submit an additional MDS record. This negatively impacts the CMS quality measures. A state may collect the needed information in section S through the modification process or must collect this information outside the MDS.

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		requires a modified record. (RAI Manual; Chapter 2; Pages 35-36; September 2010). We have received information that the following states require a modification of the Discharge Assessment from "return anticipated" to "return not anticipated" in the circumstance indicated above: Florida North Dakota South Dakota Not allowing modifications for ARD or reason for assessment: I assume a rejection would occur if the user attempted to modify an assessment for changes here. I also assume that inactivations would now be used for these kinds of changes?? Will the RAI manual be updated to show these changes?	
20110126-005	A - Policy	Beginning April 1, we are to do inactivations when changing the target date or assessment type. Is it recommended that facilities begin doing that now?	Yes An inactivation is required when the provider must correct reason for assessment or a target date.
20101220-001	A - Policy	We (vendor) have a central database and we must use automated scripting; what are you suggesting we do to replace that?	CMS is not suggesting an alternative; simply advising that the system was not designed for automated scripting and we must insist that vendors stop using it.
20101220-002	A - Policy	CMS received a vendor question on the display of RUG III values for an assessment.	The RUG III group will be displayed on validation reports for assessments with a target date from October 1 through November 1, 2010. The ASAP system does not display the RUG III for insurance purposes.
20101220-003	A - Policy	CMS received a question regarding HIPPS codes for an assessment.	The specifications for HIPPS code and Medicare short-stay assessments have been available for several months on the CMS website. They are also included in Chapter 6 of the RAI manual. The DLL, calculating the HIPPS code and Medicare short-stay, is available in the RUG IV grouper package. The DLL can be called from a variety of languages: Visual Basic, C++, and Java. The RUG IV grouper package also included SAS and C++ modules for calculating the HIPPS code and the Medicare short-stay indicator.

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20101220-004	A - Policy	Can additional lines be added in Z0400 for staff signatures?	Yes, additional signature lines may be added.
20101101-001	A - Policy	If any resident had therapy in the past, but now is either off Medicare or is on Medicare and skilled for nursing issues only, does the facility complete the start and end dates of all therapy received?	Update: The MDS states the following in the instructions for coding therapy start and end dates: "Record the date the most recent therapy regimen (since the most recent entry) started" and "record the date the most recent therapy regimen (since the most recent entry) ended- enter dashes if therapy is ongoing." Provider should follow the instructions on the MDS.
20100926-004	A - Policy	In 2003 CMS required nursing homes to backup their local database to safeguard their MDS 2.0 information. Is this required for MDS 3.0?	Yes. Nursing Homes should back up their local databases. jRAVEN has a backup utility for the provider to use to back up their database. Other vendor software should also have a method of backing up the data.
20100926-003	A - Policy	We have had several clients inquire as to when to begin documenting Concurrent Therapy Minutes. For example, an MDS 3.0 assessment with an ARD of 10/1/2010 would look back 7 days to Sept 25th. Normally during that time, providers would be providing therapy to residents in either individual or group mode … by doing so, the therapy that would be included on the 10/1/2010 MDS 3.0 would be listed as either all individual and/or group which could overstate the individual therapy since concurrent was not recorded even if it had been provided. Providers are wondering if this is allowable or if they should be documenting individual and concurrent therapy beginning on Sept 25 for those assessments performed in October that will look back into the latter part of Sept?	Providers should be recording the mode of therapy beginning, at the latest 9/25/10, in order to code the MDS 3.0 accurately in early October. If the provider does not record according to the modes, then they will not be able to complete item O0400.
20100926-002	A - Policy	When a facility sends in a combined assessment: A0310A set to 01 (Admission), or 02 (Quarterly), or 03 (Annual), or 04 (Significant Change in Status), or 05 (Significant Correction to prior comprehensive assessment), or 06 (Significant Correction to prior Quarterly assessment) AND A0310F set to 10 (Discharge - return not anticipated), or 11 (Discharge - return anticipated)	1. If a record had A0310A=01, 02, 03, 04, 05, 06 and a discharge (A0310F=10, 11), it would qualify both as a regular OBRA assessment and as a discharge. Note that the assessment reference date must equal the discharge date or the combination is not valid and will be rejected. 2. If an assessment has a reference date on or before the date of a temporary discharge with the resident later

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		1. How is this assessment viewed? -- As a discharge? As a regular assessment? Or as both? 2. When a combined assessment is submitted, that resident is discharged. So when/if the resident returns, would the facility submit an entire new assessment on that resident OR would the facility retrieve the combined assessment that contained the discharge and update and re-submit that one (i.e. remove the A0310F code of discharge and then continue on with the full assessment with a '99' in the A0310F field)? If combined assessment - reused… 2a. If the combined assessment is re-used is there a time limit on when it can be re-used? 2b. Also if combined assessment re-used, how does that affect the ASSESSMENT_ID field? Is a new ID assigned to it? Or does the ASSESSMENT_ID remain the same?	returning to the facility, then that assessment and the existing OBRA assessment schedule remain in effect if the following 2 conditions are satisfied: 1. The discharge was with return anticipated (A0310F = 12) and the resident returns within 30 days of discharge. 2. A significant change in status has NOT occurred. If the discharge was with return not anticipated (A0310F = 11), then a new admission assessment is due after the resident returns and the OBRA assessment schedule restarts. If the resident was discharged with return anticipated but has been out of the facility for more than 30 days, then a new admission assessment is due after the resident returns and the OBRA assessment schedule restarts. If the discharge was with return anticipated and the resident returns within 30 days with a significant change in status, then a significant change in status assessment is due after return and the existing OBRA assessment schedule continues. 2b. Each submitted record is assigned a unique ASSESSMENT_ID value.
20100820-003	A - Policy	Will the MDS Correction Policy Provider Instructions Manual (dated October 2002) be updated for MDS 3.0?	The MDS 3.0 correction Policy has been updated and is located in Chapter 5 of the MDS 3.0 RAI Manual posted on the CMS MDS 3.0 website at http://www.cms.gov/NursingHomeQualityInits/45_NHQIMDS30TrainingMaterials.asp#TopOfPage.
20100720-039	A - Policy	1) RAI Manual 3.0 Page 5-10 says that an incorrect A0200 makes the MDS invalid, which suggests that A0200 cannot be changed with a standard modification. 2) RAI Manual 3.0 Page 5-12 does not list an incorrect A0200 as one of the reasons for a special manual record correction request. Regardless of what the RAI Manual says, you tech guys know what the system wants and allows. Can A0200 be changed with a modification? Or do users have to submit a special manual record correction request?	Summary answer: 1) True. A0200 cannot be changed using a modification request. 2) Users must submit a special manual request to their state agency to delete the records with the incorrect A0200 and fac_id. Then users must submit the records as originals using the correct A0200 and fac_id. Notes: 1) If the A0200 item was incorrect for the fac_id submitted on the original record, then the system will not be able to determine the provider of the record. The record would receive fatal error -3693a and not be accepted. If the

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			original record is not accepted, a modification record will not be accepted and should not be sent in. 2) A modification cannot be used to change the provider the record belongs to. The provider cannot be changed using automated corrections. If the provider on the original record does not match the provider on the modification record, then they get error -1058: "Unable to Modify Data: The submitted value for the FAC_ID or Submission Requirement (A0410) item in the corrected record does not match the values previously submitted for the matching record. The Facility ID and Submission Required items cannot be changed with a modification request." A manual deletion request must be submitted by the state to the QIES Help Desk to delete the records assigned to the wrong provider. New original records should then be submitted to the correct provider.
20100720-035	A - Policy	The short stay documentation refers to previous assessments. In the text "A PPS 5-day (A0310B = 01) or readmission/return assessment (A0310B = 06) has been completed. The PPS 5-day or readmission/return assessment may be completed alone or combined with the Start of Therapy OMRA" it seems like the documentation is telling us to look at previously completed assessments but the CPP code and the DLL cannot do that since it is feed only the current assessment. Can you provide some clarity on this point? Do we ignore that portion of the logic or do we need to find the previous assessments?	The second condition for an assessment to be classified as a Medicare Short Stay Assessment is as follows: "2. A PPS 5-day (A0310B = 01) or readmission/return assessment (A0310B = 06) has been completed. The PPS 5-day or readmission/return assessment may be completed alone or combined with the Start of Therapy OMRA." According to Medicare SNF PPS assessment requirements, a stand-alone Start of Therapy OMRA should never be performed before the 5-Day or Readmission/Return assessment for a Medicare stay. If a Start of Therapy OMRA is performed and the 5-Day or Readmission/Return assessment has not yet been performed, then the following Medicare SNF PPS requirements apply: a. That unscheduled Start of Therapy OMRA assessment replaces the scheduled 5-Day or Readmission/Return assessment. A subsequent 5-Day or Readmission/Return assessment is not allowed. b. The assessment should be coded as both a Start of Therapy OMRA and a 5-Day or Readmission/Return assessment.

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			c. All requirements for both the Start of Therapy OMRA and the 5-Day or Readmission/Return assessment must be satisfied. It is the facility's responsibility to insure compliance with these requirements. Any Start of Therapy OMRA assessment that complies with these requirements will automatically satisfy the Medicare Short Stay Assessment condition #2 above. It is not necessary that the standard RUG-IV grouper (DLL or SAS code) actually test the second condition, since it should always be true. Private software vendors, who develop their own RUG-IV classification code, need not test the second condition when classifying a Start of Therapy OMRA assessment as a Medicare Short Stay assessment. However, software vendors may want to alert the facility when a Start of Therapy OMRA precedes the 5-Day or Readmission/Return assessment. The facility would be advised that this is not allowed and the facility must combine the Start of Therapy OMRA assessment with the scheduled 5-Day or Readmission/Return assessment.
20100720-016	A - Policy	A draft version of an MDS 2.0 vs. 3.0 crosswalk was published in August 2008. I was wondering if there is an updated version of that document available.	The cited crosswalk has been withdrawn by CMS. CMS is not providing an MDS 2.0 to MDS 3.0 crosswalk of all items. The crosswalking of items is a judgment decision and depends on the purpose of the crosswalk. The only crosswalk supported by CMS is the RUG III MDS 3.0 Mapping Specs currently posted on the CMS Technical web page.
20100720-006	A - Policy	I have been running our outputs through the VUT to compare its results to our validator. We still have a fundamental disagreement with Part B of edits -3662 through -3667. Part B always states that the number of pressure ulcers present at admission must be less than or equal to the number present now. This requirement does not allow for the resident to be “getting better” (i.e, have fewer ulcers now than they did at admission). Consider the simple scenario of a resident arriving from another facility with one Stage 3 ulcer, and at the time of assessment (not just an admission assessment, it could be a year later!) it has improved to become a Stage 2. The	The way pressure ulcers are staged on MDS 2.0 will be different in MDS 3.0. On MDS 2.0, if a stage 3 pressure ulcer improves, it can be re-staged as a stage 2. This is called "back staging". MDS 3.0 does not allow back staging. Once an ulcer reaches stage 3, for example, it is always considered a stage 3 pressure ulcer even if it later improves (or goes away entirely). Consider M0300C1 and M0300C2 as examples. M0300C1 asks for the current number of stage 3 pressure ulcers. M0300C2 asks the assessor to indicate how many OF THESE pressure ulcers were present when the resident entered the facility. Thus, the ulcers included in M0300C2

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		assessor is required to put a “1” in M0300B1, a “0” in M0300B2, a “0” in M0300C1 and a “1” in M0300C2. Edit -3663 will fail the submission because the “1” in M0300C2 is greater than the “0” in M0300C1.	will always be a subset of those that are included in M0300C1. This means that the count in M0300C2 must always be less than or equal to the count in M0300C1. Your example of a stage 3 ulcer improving and becoming a stage 2 ulcer could happen on MDS 2.0 because of back staging, but is not allowed on MDS 3.0.
20100720-004	A - Policy	Thank you for the Power Points. Is there a way that I can get the password so I can edit the slides? I have only been able to open them as a 'read-only' file.	The Power Point slides on MDS 3.0 training issues were re-posted back without password protection.
20100720-002	A - Policy	In the state copy field of DMS, would it be possible to input the path of a server that does not exist within the state agency? For example, is it possible to bypass a separate state agency server and copy the data straight to our Medicaid agency/their contracted data custodian? They have a current DUA in place.	As long as the Medicaid Agency has a DUA and the state opens the appropriate connections for the copy utility it is permissible to copy the data straight to the Medicaid Agency/their contracted data custodian.
20100420-Ad Hoc24	A - Policy	If we ran out of room to list all the individuals who contributed answers to an assessment, do you expect vendors to track that on the side and provide it if a surveyor wants that information? Do you expect software vendors to audit who actually answered every question in the assessment?	This should not be any different than how it is handled in MDS 2.0. We don’t have a process for you to audit each person completing items in the assessment.
20100420-Ad Hoc23	A - Policy	I have a question regarding signatures in the Z0400 series. Does every section require that each person answering a single question in the assessment actually need to be listed in the Z0400 series of signatures or just the people who are signing off on the entire section itself?	Whoever completes any item on the assessment has to attest to the accuracy of how he/she responded. If one clinician only answers one item, his/her signature should be there.
20100420-Ad Hoc18	A - Policy	Will CMS offer any guidance in printing rules? Is there any concern by CMS whether or not sections break in the same place, if the same fonts are used, or if an entire section is not printed when it is not actually part of that particular assessment?	CMS has no requirements for printed documentation. When surveyors go out and want to see documentation at a facility, CMS has no particular formatting requirements in that environment. We simply have the requirement that the data has to be available. It is not our call to take on the role of dictating what printed copy should look like.
20100420-Ad Hoc07	A - Policy	If a significant change in status assessment is noted prior to a 90-day scheduled assessment, how is the subsequent schedule affected? For example, on a 60-day assessment, if a significant change is triggered, when would the next scheduled assessment take place?	A significant change in status will be the same as 2.0. In your example, a quarterly will be due next (after the significant change in status) and the significant change assessment resets when the annual is due. That has not changed from MDS 2.0 to MDS 3.0. What has changed is that the next assessment is based on the ARD in MDS 3.0—not on the completion of the assessment.
20100420-Ad Hoc04	A - Policy	Some nurses asked if validation reports will be in electronic format or just printed?	Whenever CMS puts documentation out for public use, it has to be 508 compliant (accessible to individuals with disabilities) and the PDF format is the most universal 508

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			compliant document; validation reports will be PDF format. Post Meeting Note: The automatically generated Facility Final Validation Report (FVR) that is placed in the facility's shared folder will be a text file similar to the MDS 2.0 Final Validation Report. When a CASPER user runs the CASPER Submitter Final Validation Report or Facility Final Validation Report, it will appear in the user's Inbox as a .pdf report.
20100420-35	A - Policy	Can you please tell us where to get specific information regarding quality measures for MDS 3.0?	Information on the MDS3.0 Quality Measure can be found on the CMS website http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html
20100420-29	A - Policy	Is there an MDS 3.0 sample data set that can be used for statistical analysis?	No.
20100420-18	A - Policy	I would like to clarify something related to the use of the MDS 3.0 forms. We would like to use the MDS 3.0 PDF forms, as they are formatted, in our software. Would there be any copy write restrictions related to that? Our intent is to simply allow the user to fill out the PDF to complete the MDS. None of the copy written material currently a part of the MDS would be used outside of the PDF form.	You would not be infringing on any copyrights by using our PDF version of the form.
20100225-094	A - Policy	Is there a regulation that assessments must be submitted in order? Example: The resident is discharged for 1 day. The Entry record is submitted on the Entry Date + 14. The Discharge Assessment is submitted later the same day OR submitted 7 days after the Entry record. Since both were submitted within the required submission period, is there an issue with their being submitted out of order?	Records submitted in the same file are sorted by target date prior to processing. Records submitted in separate files on the same day are processed in order of submission date and time. If 2 records have the same target date and are submitted in the same file or in separate files with the "earlier one" submitted prior to the "later one", or if they are submitted in files with different user IDs, then there is a possibility of receiving sequencing warning messages from the submission system.
20100225-084	A - Policy	What is the definition of the start of a therapy regimen? Is it the Initial Eval/Re-eval date or the date that the 1st therapy treatment was given?	Evaluation date.
20100225-083	A - Policy	What do we do regarding Insurance companies who require a Medicare assessment? How is the RFA coded? May the user perform a PPS assessment for private pay/insurance?	Private insurance companies may require providers to follow the SNF PPS assessment schedule. Item Z0300 allows providers to obtain a payment code for private insurance for this purpose. These RUG values (Z0300A and Z0300B) are not submitted items on a record. Private insurance companies determine their own reimbursement method, which may not be RUG-IV 66. Providers should inform their vendor what their individual needs are. Item

ID	Topic	Question	Answer
			A0310B is for Medicare Part A assessments. If an assessment is required for private insurance, A0310B would be coded '99', A0310C would be coded '0', A0310E coded '0', and A0310F coded '99'.
20100225-082	A - Policy	What is the consistency rule for the Start of Therapy date? Must it be on or after the admission date? (a. Resident was receiving therapy and was discharged to the hospital for 24 hours. Does the original SOT date continue, or is there a new SOT date for the reentry into the facility?) (b. Resident was transferred from Nursing Facility A to a sister facility B. Does the original SOT date continue?)	As with MDS 2.0, therapy services may only be coded on the MDS 3.0 since admission into the facility or since returning to the facility.
20100225-070	A - Policy	What form options will each state have for completing a quarterly assessment? The NQ or NC? The NQ and NP appear to be identical. True? If so, then there would be no advantage to a state using the NP form?	The States must at a minimum use the quarterly item set for their quarterly and the PPS item set for PPS assessments. From a Federal perspective, the quarterly and PPS items sets are identical. However, States may add items from the comprehensive item set to quarterly and PPS assessments, and different items can be added to each type. When a combined assessment is completed, then any items that are contained in either item set must be submitted. Thus, if a State added items to the quarterly but did not add items to the PPS assessment, then if a combined quarterly/PPS assessment was submitted it must contain all of the items on the State's quarterly.
20100225-064	A - Policy	ID 00012d. – I didn't see a response to the portion of the question dealing with corrections. If you have a record that was accepted into the MDS 2.0 State database with an ARD before 10/1/2010, but the error was discovered after 10/01/2010, how will we correct that record? Using the MDS 2.0 system or the MDS 3.0 system. How long will the MDS 2.0 system be "up" for MDS 2.0 correction purposes?	If a provider inactivates or modifies an MDS 2.0 record, then the provider would submit this info through the MDS 2.0 system. However, when a provider determines a significant correction to a prior record must be completed, the provider would complete the assessment according to the ARD for the significant correction record. If the ARD of the significant correction to prior assessment is 10/1/10 or later, the provider must complete an MDS 3.0 and submit to the MDS 3.0 system. If the ARD is 9/30/10 or earlier, then the provider must complete an MDS 2.0. CMS has not determined an end date to MDS 2.0 submissions at this time.
20100225-056	A - Policy	In MDS 2.0, a modification request could not be done if: o There was a change in rec_type (i.e. aa8a or aa8b) o Or there was a change in resident information (e.g. name,	The MDS 3.0 Correction Policy allows more automated corrections than the MDS 2.0 Correction Policy. This Policy is documented in Chapter 5 of the RAI –Manual. Per Chapter 5: The Modification Request is used to modify most MDS

ID	Topic	Question	Answer
		gender, SSN, dob, etc.) that resulted in a new resident ID being assigned. Thus the resident in the prior section of an inactivation had to be the same resident identified in the AA section of the same record. From our understanding the only data could be changed from the data that represented a unique assessment (facility, resident, assessment type, & target date) was the target date (i.e. a3a, a4a, or r4). Do these same rules apply for MDS 3.0?	items. The exceptions are: — An Inactivation of the existing record followed by submission of a new corrected record is required to correct: Type of Provider (Item A0200), — Type of Assessment (A0310), — Entry Date (Item A1600) on an Entry tracking record (A0310F = 1), — Discharge Date (Item A2000) on a Discharge/Death in Facility record (A0310F = 10, 11, 12), — Assessment Reference Date (Item A2300) on an OBRA or PPS assessment. An MDS 3.0 Manual Assessment Correction/Deletion Request is required to correct: — Submission Requirement (Item A0410), — State-assigned facility submission ID (FAC_ID), — Production/test code (PRODN_TEST_CD).
20100225-053	A - Policy	We see that the MDS form has copyright information at the bottom of some section pages. For example – Section D has "*Copyright © Pfizer Inc. All rights reserved. Reproduced with permission."* Does Copyright information need to appear on entry screens that we develop or only on printed forms?	The copyright needs to appear on all versions of the MDS 3.0 either on screen or on paper.
20100225-049	A - Policy	How does the Care Area Assessment impact the Care Area Assessment triggers? I see that CMS came out with the care area assessment but did not change anything with the Care Area Assessment triggers. There is a lot more to the assessment than there is to the triggers.	The MDS 3.0 ASAP software uses the information sent in the assessment to determine whether a trigger occurs or not. From there, a care area assessment is warranted if an area triggers. Detailed information is available in chapter 4 of the MDS 3.0 RAI Manual.
20100225-044	A - Policy	Will the government provide an XML Collection Schema (for Microsoft SQL Server)?	No
20100225-039	A - Policy	CATs Worksheets Will CAT worksheets be developed? If so, what is timeline for vendor specs?	Appendix C of the RAI Manual has this information.
20100225-012	A - Policy	For most of the interviews, the initial question to determine whether the resident interview can take place involves whether the resident can be understood. If they are rarely/never understood, the interview is skipped and a staff assessment is generally completed. Since field B0700 Makes Self Understood refers to a resident being understood and answer 3 = Rarely/Never Understood, will there be a link	There will be no linkage for edits between items involving B0700.

ID	Topic	Question	Answer
		between this question and the initial interview question(s)? (For example, if B0700 = 3, then C0100 = 0, etc.)	
20100225-005	A - Policy	If a correction needs to be submitted for an MDS assessment that CMS has already accepted, is there a time limit on submitting such correction (i.e., only have X # months to submit corrections for accepted MDS forms)? Same question for rejected assessments - does a hospital need to submit within a certain time frame after an MDS is rejected by CMS?	There is no time limit for a correction. An assessment is not in compliance until it is 'accepted' so the 14 day window is the time frame.
20100114-058	A - Policy	In MDS 2.0 we had RAP worksheets. Will there be similar worksheets associated with CATS in 3.0?	There is no mandatory worksheet that needs to be completed for MDS 3.0. There is a set of tools that you will see when Appendix C is posted, that can be used voluntarily by nursing homes.
20100114-057	A - Policy	Will the QIS specifications be adjusted for the changes in MDS 3.0?	Yes, they will be. We are still working out the details of when that will happen because of software release schedule.
20100114-055	A - Policy	Can you mention the dates that will drive the decision on 10/1/2010 regarding which assessment should be completed, MDS 2.0 or MDS 3.0? The Ab1 date and the A3a date are on the admission assessment. Which date takes priority?	There is no AB1 date. There is an entry date in A1600 that has to be completed on every record and it is the most recent admission or re-entry date. However, this date has nothing to do with the requirement for when an assessment should be an MDS 2.0 or MDS 3.0 assessment. The decision about whether to complete and submit an MDS 2.0 or MDS 3.0 assessment is completely based on the ARD (A2300).
20100114-044	A - Policy	What is the significance of requiring an entire MDS assessment done at discharge rather than the current process of just a discharge tracking form? Will this translate into any additional logic required for processing a discharge?	It gives us more information at discharge & assists with both quality measurement & survey programs.
20100114-040	A - Policy	If a printed copy is still required, what will need to be printed? – will skipped sections need to be printed?	Print the active items for whatever ISC the assessment is, including items that are part of a skip pattern. You are not required to print inactive items.
20100114-039	A - Policy	We have heard that the 3.0 assessment is meant to be an 'on-line' assessment. Does that mean a printed copy will not be required in the chart? How will signatures be handled?	From section Z in the RAI manual: Nursing homes may use electronic signatures for medical record documentation, including the MDS, when permitted to do so by state and local law and when authorized by the nursing home's policy. Nursing homes must have written policies in place that meet any and all state and federal privacy and security requirements to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs. Although the use of electronic signatures for the MDS does not require that the entire

ID	Topic	Question	Answer
			record be maintained electronically, most facilities have the option to maintain a resident's record by computer rather than hard copy.
20100114-030	A - Policy	How do you expect the workflow of daily documentation to be affected by the change of MDS 3.0? We are especially concerned with Section E for Behavior.	CMS has no requirement for this feature.
20100114-026	A - Policy	In CH3: MDS Items [X], Page X-12, there is a line that reads, "The entire correction request should be completed and signed within 14 days of detecting an error in an MDS National Repository record. A hard copy of this request, including the signature of the attesting facility staff, must be attached to the modified or inactivated MDS record and retained in the resident's record, regardless of whether the facility maintains a paper or an electronic clinical record system." a. This requirement does not exist anywhere else in the RAI manual, so why would only the correction/inactivations need to be printed and put in the resident's record? It was felt that the government and long-term care industry were trying to move to electronic systems. This requirement seems to force us back to the paper process. b. If a hard copy of this request needs to be put in the chart, do the staff signing X1100D need to physically sign the hard copy of the MDS record, or does the electronic signature cover the requirement?	From section Z in the RAI manual: Nursing homes may use electronic signatures for medical record documentation, including the MDS, when permitted to do so by state and local law and when authorized by the nursing home's policy. Nursing homes must have written policies in place that meet any and all state and federal privacy and security requirements to ensure proper security measures to protect the use of an electronic signature by anyone other than the person to whom the electronic signature belongs. Although the use of electronic signatures for the MDS does not require that the entire record be maintained electronically, most facilities have the option to maintain a resident's record by computer rather than hard copy.
20100114-025	A - Policy	There are questions in section A that have changed (A1800 & A2100), which will impact the UBs. Has this been identified and will requirements for the billing side be released and if so, when?	Requirements for claims regarding 'entered from' and 'discharge status' have not changed.
20100820-002	B - 672/802	Was the SOM ever updated to include a new version and crosswalk for these forms? Looking through the CMS site manuals, I have been unable to locate an updated version of these forms.	Appendix PP & Forms 672, 802, & 805 of the SOM will be released as an advanced copy through a S&C letter with accompanying training materials on August 27, 2010, with full implementation in the actual SOM & CMS forms site on October 1, 2010. SOM Appendix P changes were released through an S&C letter (S&C 10-27-NH) with accompanying training materials on July 30, 2010. Chapter 4 revisions to the SOM, which are related to Section S implementation & RAI designation by the state, will be completed in September.
20100225-001	B - 672/802	I see no reference to report Form 672 - Census & Conditions Summary, or 802 - QI Matrix.	The revision to Appendix P of the SOM that includes the 672/802 is in the process of clearance.
20100820-040	C -	Will CMS allow providers to transmit either MDS 2.0 or MDS	Assessments with an ARD of 10/1/10 or later, entry records

ID	Topic	Question	Answer
	Policy 10/01/2010	3.0 through the end of 2010 (Oct – Dec) to allow providers time needed to transition their systems and software?	with an entry date of 10/1/10 or later, and death in facility records with a discharge date of 10/1/10 or later will be MDS 3.0. A MDS 3.0 with a target date earlier than 10/1/10 will not be accepted into the QIES MDS 3.0 ASAP System. Records with earlier target dates should be MDS 2.0 records submitted to the state MDS 2.0 system.
20100225-065	C - Policy 10/01/2010	I have been reading all available documentation on the MDS 3.0 submission file changes, and I cannot find a hard rule that states MDS 2.0 and MDS 3.0 assessments must be submitted separately. Although, with the change from ASCII to zipped XML, I am making the assumption that a facility must separate the two groups and submit MDS 2.0 assessments separately from MDS 3.0 assessments. Is this a correct assumption?	Yes, your understanding is correct. MDS 3.0 records must be submitted to the MDS 3.0 submission system and MDS 2.0 records must be submitted to the MDS 2.0 submission system. The files for each system must follow the Data Specifications for the appropriate submission system.
20100225-045	C - Policy 10/01/2010	How will corrections and deletions for MDS 2.0 Assessments be handled after October 1?	Modifications and inactivations will be handled as they are today. The provider will need to submit any 2.0 records to the 2.0 system.
20100225-007	C - Policy 10/01/2010	I understand that as of 10/01/2010, using the ARD/entry date/discharge date, an MDS submitted with that date or beyond must be MDS 3.0. My question is how do we know which date to use when an assessment has all three of the above dates included in it. In several places in the specs, a target date is defined as follows: a) If A0310F is equal to [01], then the target date is equal to A1600 (entry date). b) If A0310F is equal to [10,11,12], then the target date is equal to A2000 (discharge date). c) If A0310F is equal to [99], then the target date is equal to A2300 (assessment reference date). Is this target date logic to be used to determine which date to evaluate against the 10/01/2010 date and thus whether the assessment should be considered MDS 3.0 vs. MDS 2.0?	Assessments with an ARD of 10/1/10 or later, entry records with an entry date of 10/1/10 or later, and death in facility records with a discharge date of 10/1/10 or later will be MDS 3.0. A MDS 3.0 with a target date earlier than 10/1/10 will not be accepted into the QIES MDS 3.0 ASAP System. Records with earlier target dates should be MDS 2.0 records submitted to the state MDS 2.0 system. The target date is defined as the dates cited in the prior sentence, so yes, the target date is evaluated against the 10/01/2010 date to determine whether to submit to MDS 3.0 or MDS 2.0.
20101101-003	D - RAI Manual	We are getting feedback from our clients about a validation issue when C0100 is blank that they can go directly to C0700 and start entering data. Please refer to the bottom of 29 and top of page 30 from the attached Users Guide. Tip: This is a skip pattern. If C0100 is 0 or blank (^), then skip to C0700 (Short-term Memory OK) or the next active item.	The RAI Manual is correct. C0100 can be '0 or ^' as it is part of an earlier/larger skip pattern in B0100 Comatose (If B0100 = 1, skip to G0110). Therefore it can be '^'.

ID	Topic	Question	Answer
		This does not seem logical as there are "skip patterns" revolved around answering C0100. Thus, C0100 should have a value (shouldn't be blank) in order for the user to appropriately complete the BIM (C0200 to C0600) or be required to complete the staff assessment (starting on C0700). Can this tip be removed from the RAI Manual?	
20100420-Ad Hoc08	D - RAI Manual	With MDS 2.0, a list was provided with actual item and response numbers for the items that triggered a significant change. Will we receive a list for MDS 3.0?	As in 2.0, with 3.0 we give examples of what a significant change in status may be. The list in Chapter 2 is not an all-inclusive list. This should not be considered to be the only circumstances when a change in status needs to be completed. The decision needs to be based on the individual's status. The decision is the inter-disciplinary team's judgment. There is no triggering.
20100225-078	D - RAI Manual	It is implied but not stated in RAI chapter 5. Is it true that an Inactivation cannot be Inactivated?	Yes. Accepted inactivations cannot be modified or inactivated. If an accepted inactivation was done in error, then a new assessment must be submitted.
20100225-076	D - RAI Manual	**Page 2-45: Under Section 2.11 Combining OBRA Assessments and Medicare Assessments** there is a paragraph that says: "The OMRA item sets are all unique item sets and are never completed when combining with other assessments. For example, a **Start of Therapy OMRA** item set is completed only when an assessment is conducted to capture the start of therapy **and** assign a RUG-IV therapy group. In addition, a **Start of Therapy OMRA and Discharge** item set is only completed when the facility staff chooses to complete an assessment to reflect the start of therapy and discharge from facility." What does this mean?	The OMRA item sets do not contain all the needed items for payment, quality, and care planning. If an OMRA is combined with another type of assessment that includes a larger set of items, the larger set of items must be completed. For example, if a provider wanted to combine a Start of Therapy OMRA with an OBRA admission assessment, the provider must complete the comprehensive item set that is required for an OBRA admission assessment. If a Start of Therapy OMRA is combined with a Discharge, then the Discharge item set must be completed.
20100225-071	D - RAI Manual	Chapter 2, page 8: If a provider combines an OBRA or PPS assessment with a discharge assessment, the ARD (A2300) and discharge date (A2000) **must** match per the RAI Manual. However, if the resident is discharged at 9 a.m., the provider obviously cannot observe beyond that time. Doesn't that contradict the above definition of an ARD covering the whole day until 11:59p.m.?	When a discharge assessment is performed, whether or not combined with another assessment, the ARD is the discharge date. In this case, the ARD will necessarily be a partial day. This is the only case where an ARD does not cover the whole day until 11:59 pm.
20100225-037	D - RAI Manual	Could there be a single page somewhere on CMS for Case Mix contacts by state like there is for the RAI Coordinators by state? Believe it or not, asking RAI Coordinators what their specifications are for case mix in their state does not always get an answer.	CMS will take this under consideration.
20100926-007	D – RAI	1 - While combining Swing Bed Clinical Change Assessment	Please consult Chapter 6 of the RAI Manual for information

ID	Topic	Question	Answer
	Manual	and Start of Therapy OMRA, A0310B value is coded as 07 (Unscheduled assessment used for PPS). How will the resultant RUG code from the combined assessment impact the PPS period? Should we check the ARD date of the combined assessment and see which PPS payment period it falls under and then either replace the entire period or from ARD date onwards? 2 - An extension to the above question; Start of Therapy OMRA will affect the payment period starting from the earliest of the ST/OT/PT start dates till the end of coverage, while Swing bed will follow SCSA logic. How will we determine the start date as of when the new RUG score will impact the payment period? 3 - Similarly while combining Start of therapy OMRA with SCSA assessments, How should we code A0310B? How will this impact the PPS payment period.	relevant to these questions. All of the questions refer to unscheduled assessments used for PPS (see Chapter 6 Table 3). Scheduled PPS assessments establish the RUG payment group for the standard payment periods. Unscheduled assessments used for PPS can only revise the RUG group for part of a payment period already established by a scheduled PPS assessment. A start of therapy OMRA is an unscheduled assessment that will revise the standard period payment group from the earliest start of therapy date (SLP, OT, or PT) to the end of the standard payment period. It does not affect the RUG group from the start of the standard payment period to the earliest start of therapy date. Those earlier days are not billable unless a scheduled assessment has already been performed. If the scheduled assessment has not been performed before the unscheduled assessment, then the unscheduled and scheduled assessments should be combined and rules about late scheduled assessments (after the allowable assessment window) may apply. A nursing home significant change or swing clinical change assessment is an unscheduled assessment that will revise the standard period payment group from the assessment ARD to the end of the standard payment period. It does not affect the RUG group from the start of the standard payment period to the assessment ARD. Those earlier days are not billable unless a scheduled assessment has already been performed. If the scheduled assessment has not been performed before the unscheduled assessment, then the unscheduled and scheduled assessments should be combined and rules about late scheduled assessments (after the allowable assessment window) may apply. If a start of therapy OMRA is combined with a nursing home significant change or swing bed clinical change, then the RUG group will be revised as of the earliest start of therapy date.
20121210-002	E-Specs	I have a quick question on inactivations; unfortunately the RAI manual doesn't really specify this or I can't seem to find	When you submit either an inactivation or a modification record, the target date in item X0700 must match the target

ID	Topic	Question	Answer
		it We were wondering for inactivation item sets what the target date was. Is it the ARD of the original assessment or does it have its own ARD. Reason we ask is because we're trying to determine what the item set version of an inactivation should be. The scenario is: Assume an assessment was submitted with a 9/28/12 ARD. However, on 10/2/12 it was then inactivated. What should the ARD of that 10/2/12 assessment be, 10/2 or 9/28? And also, if it's the latter, does that mean that the item set version of the inactivation should be the same as the original (I understand that the item set version number has not changed for the 10/1 cross-over. This is a hypothetical situation that will eventually be a scenario in the future) We have the same question for modifications.	date of the original record so that the ASAP system can find the record that you are trying to inactivate or modify (see Edit -3745). Under the currently active data specifications (v1.11), the target date of the modification record must match the date in item X0700 (see Edit -3811). Note that beginning on May 19, 2013 (when version 1.12 is implemented), this edit will no longer apply. This means that for modifications submitted on or after 5/19/2013, you will be able to change the target date so that the target date of the modified record is different from the target date of the original record. In any event, the version of the data specs that applies to a record (whether it is a new, modified, or inactivated record) is always controlled by the record's target date, regardless of when it is submitted. This means that the record's target date is used to determine which version of the data specs applies and which set of edits will be used to check the record. Please refer to the item values for the control item SPEC_VRSN_CD for a list of the effective dates for each version of the data specs. A similar table is shown near the beginning of the data specs overview document that accompanies the data specs.
20121210-003	E-Specs	I want to verify that our assessments with a Target Date on or after October 1, 2012 will be accepted without error. We programmed our submission file as instructed below, with SPEC_VRSN_CD = [1.11] when the Target Date = 10/01/2012. However, in the overview of the Submission Specifications v1.12 on page 1 bullet 1, it is noted that the fix for issue #01 from the last errata document will be incorporated in the V1.12.0 update. I did run my test assessments through the VUT tool and received results without an warning error for the SPEC_VRSN_CD, but the information in the v1.12 overview document has me concerned. So, will SPEC_VRSN_CD =	Yes, the assessments will be accepted with 1.11 in the value for SPEC_VRSN_CD as the edit on the SPEC_VRSN_CD is only requires that the submitted value be in the list of valid values in the Data Specifications. The value of 1.11 was added in the MDS 3.0 Data Specifications Errata V1.11.0 for the October 1, 2012 Release. The download for this document is directly below the download for the MDS 2.0 Submission Specs for V1.11.0 for the October 1, 2012 Release [ZIP, 10MB] on the CMS Technical website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html

<table>
<tr><th>ID</th><th>Topic</th><th>Question</th><th>Answer</th></tr>
<tr><td></td><td></td><td>[1.11] be accepted as a valid value with the implementation of the October, 2012 changes?</td><td></td></tr>
<tr><td>20121210-004</td><td>E-Specs</td><td>I am reviewing the changes and noticed that SPEC_VRSN_CD does have a new value for v1.11.0.

It just list these as valid values:

Value Text
1.00 Initial version of data specifications (effective 10/1/2010)
1.01 First update to data specifications (effective 4/1/2011)
1.02 Second update to data specifications (effective 10/1/2011)
1.10 Third update to data specifications (effective 4/1/2012)

Was the change just missed in the specifications or is the value really staying 1.10?</td><td>A new entry for SPEC_VRSN_CD should have been added for version 1.11.0 of the data specs. The value list for SPEC_VRSN_CD should include the following entry:

1.11 - Fourth update to data specifications (effective 10/1/2012)

You should therefore submit SPEC_VRSN_CD = [1.11] for all assessments with a target date on or after 10/01/2012. We will add this issue to an errata document.

No changes are being made to the printable item sets for October 2012, so there are no new entries for ITM_SET_VRSN_CD.</td></tr>
<tr><td>20121210-005</td><td>E-Specs</td><td>Why does the M0900 say (OBRA, PPS or DISCHARGE)? Is the word Discharge a misprint? We use the forms provided in the CMS files. The wording doesn't affect the MDS, but our users are asking what the difference for discharge is? I've looked for some documentation and can't find any.</td><td>The wording for M0900 was changed in Version 1.10.4, Effective 04/01/2012. You can download the MDS 3.0 Item Subsets from the MDS 3.0 Technical Information page on the CMS web site: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html</td></tr>
<tr><td>20121210-006</td><td>E-Specs</td><td>We have a question on the following errata item. We read this edit is that the edit already existed and that the CMS documentation is just being updated correct? Q0500B through Q0550B was already NOT allowed to equal [^] and it was just not documented anywhere. So when you say - "However, no edit currently indicates the allowable values for items Q0500B, Q0550A, and Q0550B if Q0400A=[0,-] and A0310A=[01,03,04,05]" it just means that you are now clarifying this?

<table>
<tr><td>04</td><td>07/10/2012</td><td>***NOTE: This issue and its resolution replaces issue #02 above.

Edit -3833a</td><td>Edit -3833a should be changed to say:

a) If Q0400A=[0,-] and A0310A=[01,03,04,05], then both of the following rules apply:</td></tr>
</table>
</td><td>This is an expansion of an existing edit, not a new edit. As currently written in v1.11.0, the data specs do not specify the allowable values for items Q0500B, Q0550A, and Q0550B if Q0400A=[0,-] and A0310A=[01,03,04,05]. These values are properly specified under all other circumstances. The expanded version of Edit -3833a will allow the specs to cover all circumstances.

As stated in the errata document, this expanded version of this edit will not be implemented until the next major update of ASAP (scheduled for the October 2013 release). Therefore, the expanded edit is voluntary at this time, although we urge vendors to implement it if possible.</td></tr>
</table>

ID	Topic	Question	Answer
		currently says: If Q0400A=[0,-] and A0310A=[01,03,04, 05], then if Q0490 is active it must equal [^]. However, no edit currently indicates the allowable values for items Q0500B, Q0550A, and Q0550B if Q0400A=[0,-] and A0310A=[01,03,04, 05]. To fix this, edit - 3833a should be changed to say: a) If Q0400A=[0,-] and A0310A=[01,03,04, 05], then both of the following rules apply: ---a1) If Q0490 is active it must equal [^]. ---a2) All active items from Q0500B through Q0550B must not equal [^].	---a1) If Q0490 is active it must equal [^]. ---a2) All active items from Q0500B through Q0550B must not equal [^]. Note: It will not be possible to fix this issue in ASAP until the system's next major release. In the meantime, software vendors are urged to make to their data entry/submission software	
20121210-007	E-Specs	I have a question and was wondering if you could provide me with some insight on ICD-9 codes. A facility has brought up the fact that some of the ICD-9 codes that we allow in our application for MDS data point I8000 are not actually allowed by CMS. They referred to the following codes and their concern was that the codes with no decimal points (more	The ASAP system checks the record to determine whether the ICD-9 code submitted meets the format requirement. Please refer to the technical specifications for the required formatting at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-

ID	Topic	Question	Answer
		generic codes) are not acceptable for I8000: • 600 - Hyperplasia Of Prostate • 707.0 - Pressure Ulcer • 733.0 – Osteoporosis • 585 - Chronic Kidney Disease (Ckd) • 724.0 - Spinal Stenosis Other Than Cervical • 786 - Symptoms Involving Respiratory System And Other Chest Symptoms They claim that they have received validation errors when submitting the MDS to CMS. • I researched in the RAI manual for Section I and submission specs and there is no explicit mention of what ICD9 codes can be used other than the fact that they have to be valid codes. I checked in ICD9cm site (http://icd9cm.chrisendres.com/index.php?action=child&recordid=5909) and confirmed that the codes listed above are valid ICD9 codes • When I imported a test file into jRaven, I didn't receive any validation errors stating that these codes were not allowed • I also tried using the VUT tool from QTSO (https://www.qtso.com/vendormds.html) and did not receive a FATAL error from this tool either; however, I received the following warning message for each ICD code. <results> <message_number>146</message_number> <error_id>-3591</error_id> **<severity>WARNING</severity>** **<text>The ICD-9 code could not be found in the official ICD-9 diagnosis codes for 2011.</text>** **<item>I8000A</item>** **<item_value>^^600.^^</item_value>** </results> <results> I can't find documentation anywhere that specifically speak to	Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html When a record is submitted and it does not meet the data specifications format, the record will be rejected. The VUT also checks the format and will issue a fatal error just as the ASAP system does. In addition, the VUT compares the ICD-9 to the official list posted on the CMS web site at: http://www.cms.gov/Medicare/Coding/ICD9ProviderDiagnosticCodes/codes.html If the record contains an ICD-9 that is not listed a warning is issued. All the codes you listed as not on the official list. For example, 600 is not an official ICD-9 but 600.00 is. At this time, the ASAP doesn't compare the ICD-9 to the official list posted on the CMs site. Regardless of the checks CMS has in place for ICD-9 codes, it is the provider's responsibility to ensure they are using proper ICD-9 codes whether it be for the MDs or a claim or other document.

<table>
<tr><th>ID</th><th>Topic</th><th>Question</th><th>Answer</th></tr>
<tr><td></td><td></td><td>this issue so I was wondering if perhaps you can provide some insight. Are these types of codes not allowed?</td><td></td></tr>
<tr><td>20121210-008</td><td>E-Specs</td><td>When ICD-10 is implemented, we have questions regarding ICD-10 use in MDS. I am aware that I8000 is already designed to allow for ICD-10 values. Will an additional "indicator" item, calculated field, or control field be added to indicate whether I8000 is coded as ICD-9 or ICD-10? In other words, will something be added to the state extract file that will indicate whether I8000 is coded with ICD-9 or ICD-10?

How does CMS plan to identify which ICD code was submitted? ICD-9 vs. ICD-10 in I8000. Has ICD version detection been developed based on the first character, the number of total characters, or some other means of distinguishing ICD-9 vs. ICD-10? If not, do you plan to develop one at some point in the future that you will be able to share so others might use ICD version detection in their own coding?</td><td>The formatting of ICD-9 and ICD-10 do differ. ICD-10 requirement will be based on target date of the assessment. Prior to the implementation of ICD-10 (today's world), the specifications require the ICD-9 format and thus the ASAP edit checks any codes entered in I8000 meet the ICD-9 format described in the Data Specifications. When ICD-10 is in place, the Data Specifications will be updated for the ICD-10 release to describe the ICD-10 format expected. The ASAP edit will check the code to ensure it meets ICD-10 format. From a CMS perspective for MDS 3.0, the ICD-10 implementation will be based on target date of the assessment (A2300).

As the expected ICD code (ICD-9 or ICD-10) is based on target date not submission date, after the ICD-10 implementation date, a provider probably will still be submitting records with a target date prior to the ICD-10 implementation date. Records with a target date prior to the ICD-10 implementation date (currently scheduled to be October 1, 2014), would submit ICD-9 codes regardless of when they were submitted.</td></tr>
<tr><td>20121210-009</td><td>E-Specs</td><td>The most recent MDS 3.0 Errata lists an issue with Q0600:

<table><tr><td>07</td><td>04/26/2012</td><td>The value list for item Q0600 includes a caret (^) even though Q0600 can't be skipped. In previous versions of the specs (for assessments with target dates prior to April 1, 2012), item Q0600 could be skipped so caret was a valid value. However, beginning with V1.10.1 of the data</td><td>Caret (^) is not a valid value for item Q0600 for V1.10.1 of the data submission specifications (for assessments with target dates on or after April 1, 2012). Caret will therefore be removed from the list of valid values for Q0600. Software developers are urged to update</td></tr></table></td><td>It is not relevant when the provider’s software is updated. The provider must enter a valid code into this item. As long as the provider enters a valid code, there will be no issues. If the provider skips (^) for this item, the record will be rejected. The provider would not be able to bill Medicare when applicable for that assessment until it is accepted into the ASAP system. We are not aware of the ramifications/impact on Medicaid payment for a record being rejected.</td></tr>
</table>

ID	Topic	Question	Answer
		<table><tr><td></td><td></td><td>specs, the skip pattern for Q0600 was removed. Caret is therefore not a valid value for assessments with target dates on or after April 1, 2012.</td><td>***their software as quickly as possible to address this issue. Assessors are urged not to skip item Q0600 when it is active.***</td></tr></table> What are the ramifications to our clients if their software is not updated until later this year?	
20121210-010	E-Specs	On a discharge assessment, section O: If there are no minutes in the look back, I can enter a zero for the days. For the dates (PT, OT, ST) is blank a valid answer? Or must I enter a dash?	Edits -3557, -3558 and -3559 address this issue – consistency fatal skip pattern. Please refer to the error message chapter of the Provider Users Manual, as well as the data specifications. If an item is active, it may not be left blank. An active item must contain a valid response value. If an active item is left blank, the record will be rejected. When we refer to blank, we are saying that the item does not contain a valid response value, which in some instances, the caret (^), may be a valid value.
20111110-004	E-Specs	Appendix C contains a listing of all the items that have been added and deleted. Appendix E contains a listing of changes to items active April 1, 2012. Will CMS provide an ISC grid like that in Appendix E that contains all the changes to each ISC with v1.10.1, including new questions, deleted questions, and items that have changed ISC assignment?	CMS will not make any changes to Appendix E. The information is available if you wish to create your own a combined table. You would only need to add rows for the deleted items to the table.
20111110-007	E-Specs	In previous releases of item set PDF documents, there were field misnaming errors in terms of data tags applied to PDF fields that required hand adjustment to allow automatic printing of the PDFs. Each of the data fields has an implicit defined data tag that is part of the PDF structure and therefore, you can write programs that fill them in automatically but 3% of the fields' data tags are incorrect. The programs we write allow for hard copy printing. Will there be any attempt to put in a QA effort with the next release to correct those mistakes?	CMS is required to meet 508 requirements, which allows the item sets to be read and navigated by assistive technology. Our software meets the requirements for successful submission to the QIES ASAP system. Providers are not required to use the CMS software; however, they must ensure that the product they use meets CMS' requirements for submission. Vendors may choose to provide features above the CMS requirements.

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20111110-008	E-Specs	As of 04/01/2012 O0400A4, O0400A5, O0400A6, 00400B4, O0400B5, O0400B6, O0400C4, O0400C5 and O0400C6 have been added to the MDS 3.0 ND type of assessment. This means we can now have days with no minutes. The skip patterns do not say that is allowed.	Based on skip pattern, edits, and item set/manual instructions, you cannot have days without minutes. The item set specifically states “record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days”. Thus, there will be no days (zero) if there are not enough minutes to account for a day. For the ND item set, individual, concurrent and group minutes are not listed, thus there is not a skip pattern when the sum = 0.
20110803-001	E-Specs	I would like to confirm our interpretation of the A0600B formatting based on the Data Submission Specifications. For A0600B (Resident Medicare/railroad insurance number), can the character positions 10-12 be alphabetic, numeric or blank? Below is our understanding based on the Data Specifications along with the Edit IDs. Please verify whether our understanding is correct for the formatting of positions 10-12. (I have rephrased the Edit IDs as to eliminate any ambiguity on our part.) Also, beyond the correct field formatting of A0600B for MDS 3.0 submissions, are there any supplemental documents to assist users with ensuring that they enter a correct number in A0600B (beyond the RAI Manual)? Field max length = 12 Edit ID -3569: If the first character is numeric, then character positions 1-9 must be numeric and character positions 10-12 must be alphabetic, numeric or blank. Edit ID -3570: If the first character is alphabetic, then character positions 1, 2 **OR** 3 must be alphabetic AND if positions 2 or 3 are not alphabetic then they must be numeric; character positions 4-12 should be alphanumeric or blank.	Your interpretation of edit -3569 appears to be correct. However, your interpretation of edit -3570 would allow values which do not conform to the data specs. Your interpretation says that if the first character is alphabetic, then "character positions 4-12 should be alphanumeric or blank". Note that the original edit in the data specs says that if the first character is alphabetic, then "there must be 1, 2, or 3 alphabetic characters followed by 6 or 9 numbers". For example, according to the data specs, the following codes would be acceptable: A123456 A123456789 AB123456 AB123456789 ABC123456 ABC123456789 Your interpretation would allow these codes as well. However, your interpretation does not specify the number of numeric digits which must follow the alpha portion. Therefore, your edit would allow the following codes which do not conform with the data specs: ABC1 AB123 A12345
20110803-002	E-Specs	I have a question about editing O0450A.	Item X0900E should be checked only under the following

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		Edit -3812 b) states: If A0310C = [0,1,4] or A0310F=[01,10,11,12], then all active items from O0450A through O0450B must equal [^] But then: **Edit -3815 states:** If X0900E=[1], then O0450A must equal [1] So if I make a modification of an Admission/14-day/Change of therapy assessment (01/02/4 which is a valid assessment combination), and then check X0900E as yes, I will have conflicting edits since A0310C = 4, O0450A through O0450B must be blank but if X0900E is checked, then O0450A must equal 1.	scenario: (a) an end-of-therapy OMRA (A0310C=[2,3]) has been submitted and accepted by the ASAP system (b) there has been a subsequent resumption of therapy (c) the original EOT assessment is being modified by entering appropriate information in O0450A and O0450B. Under this scenario, X0900E should be checked (equal to "1") and items O0450A and O0450B should be completed. The question concerns a change of therapy, not an end-of-therapy/resumption-of-therapy combination. Item X0900E therefore does not apply to the scenario that is described. The edit that prevents X0900E from being checked is therefore appropriate.
20110803-003	E-Specs	This query is related to two Edit IDs: -3812 and -3815. Per [Edit ID:-3812]: b) If A0310C = [0,1,4] or A0310F = [01,10,11,12], then all active items from O0450A through O0450B must equal [^]. This means that O0450A will be skipped in case either A0310C or A0310F have above mentioned values. Per [Edit ID: -3815]: If X0900E = [1], then O0450A must equal [1]. This means that when X0900E is 1, O0450A should also be 1. Now what would happen, if X0900E is 1 and the value in A0310C is [01]? Per Edit ID -3812, O0450A should be skipped but according to Edit ID -3815, O0450A must be equal to [1]. It seems the Resumption of therapy Modification reason would be intended to only be used for an EOT where A0310C = 2 or 3, but there is no edit to prevent X0900E from equaling 1 when not an EOT assessment.	We presume the inquirer is asking what would happen "if X0900E is 1 and the value in A0310C=[0,1,4]). There is not an edit that directly controls the relationship between A0310C and X0900E. However, both of these items are related to O0450A/O0450B. If O0450A/B were skipped, then a fatal error would result because of Edit -3815. If O0450A/B were not skipped, then a fatal error would result because of Edit -3812. The scenario described (coding X0900E=[1] and A0310C=[0,1,4]) does not make sense. Item X0900E should be checked only under the following scenario: (a) an end-of-therapy OMRA (A0310C=[2,3]) has been submitted and accepted by the ASAP system, (b) there has been a subsequent resumption of therapy, and (c) the original EOT assessment is being modified by entering appropriate information in O0450A and O0450B. Under this scenario, X0900E should be checked (equal to "1") and items O0450A and O0450B should be completed. The scenario described by the inquirer involves coding X0900E=[1] when A0310C does not indicate an end of therapy. Because this scenario does not make sense, the record would be rejected.

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20110803-004	E-Specs	Can you help me out with edit 3811 which seems to prevent a user from modifying an existing assessment: "If X0100=[2] (modification record), the following rules apply: a) X0600A must equal A0310A. b) X0600B must equal A0310B. c) X0600C must equal A0310C. d) X0600D must equal A0310D. e) X0600F must equal A0310F. f) If X0600F=[99], then X0700A must equal A2300. g) If X0600F=[10,11,12], then X0700B must equal A2000. h) If X0600F=[01], then X0700C must equal A1600. Notes: Previous versions of the data specs allowed modification records to change the values of a previous record's reason for assessment items, assessment reference date, discharge date, or entry date. Beginning with V1.01 of the data specs, these items can no longer be changed with a modification record. Instead, these items must be corrected by inactivating the old record and submitting a new record".	A "modification" record is not a new assessment. It is a mechanism to correct data in an existing assessment that has been accepted into the ASAP system. A modification cannot have different reasons for assessment (RFAs) or a different assessment reference date (ARD) from the original record. The RFAs for the existing assessment are entered in the X0600 items and must exactly match the corresponding items in section A. Similarly, the ARD for the existing assessment is entered in X0700A and must match the ARD (item A2300). The RFAs and the ARD cannot be changes since you are correcting data in an existing assessment; you are not performing a new assessment. All information in the modification record must be based on the existing record ARD not a later date. Incorrect data based on the existing ARD are being corrected for that same ARD, not a later date. Here is an example. A nursing home admission assessment (A0310A = 01, A0310B = 99, A0310C = 0, A0310D = ^, and A0310F = 99) with ARD (A2300) of 6/1/2011 was accepted in the ASAP system. Later it is discovered that the UTI item (I2300) was incorrect on that assessment--the resident had a UTI as of the existing assessment ARD but item I2300 indicated no UTI. To correct the error, a modification record is constructed including an exact copy of all info from the existing record. The UTI item is then changed and Section X completed with X0100 = 2 (modification). The values in the X0600 will be exactly the same as the corresponding A0310 items. The value in X0700A will be exactly the same as A2300. If a provider determines that an assessment that has been accepted into the ASAP system has an incorrect RFA and/or ARD, then the provider must inactivate that record and complete and submit a new one.
20110803-005	E-Specs	We have noticed an inconsistency within different documents located on the CMS website for the CAA triggering logic used in the 05-ADL Functional Rehabilitation Potential Care Area. The RAI manual (Chapter 4, pages 22-24) states that the C1000 values are 0-2; however other documents within the CMS website's Technical Information page state that the	There are no errors in Chapter 4 of the technical documentation. Item C1000 (cognitive skills for daily decision making) is used in the triggering logic for CAA #5 ADL Functional Rehabilitation Potential. This item has a possible range of

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		C1000 values are 0-3. Could you please confirm the correct C1000 values that should be used within the triggering logic for the ADL Functional Rehabilitation Potential Care Area - is it (C1000 >= 0 AND C1000 <= 2) or (C1000 >= 0 AND C1000 <= 3)? • RAI Manual (starting on page 4-22 (v1.03) - states 0-2 • Located on the CMS website – MDS 3.0 Technical Information page, Downloads is MDS 3.0 CATs Specifications (V1.00.3) 08-27-2010 [ZIP 376 KB], which contains the following documents: 1. MDS 3.0 CAT Test Data Documentation (Table 2) - states 0-3 2. MDS 3.0 Items in the CAT Test Data Files Excel - states 0-3 3. MDS 3.0 CAT Specifications document - 'Items used' table states 0-3 and 'Triggering Conditions' section states 0-2	values of 0-3,-,^. This possible range of values is documented in the technical specifications for software developers in: 1. MDS 3.0 CAT Test Data Documentation (Table 2). 2. MDS 3.0 Items in the CAT Test Data Files Excel. 3. MDS 3.0 CAT Specifications document - 'Items used' table. This is all technical information for developers giving general characteristics of items used. Note that the technical documentation also provides the item length and in some cases the location of the item in the MDS 3.0 standard fixed format record. The possible range of values does not indicate the values used in triggering. The actual use of C1000 in triggering CAA #5 is given in Chapter 4 and in the "Triggering Conditions" and "Pseudocode (SAS)" sections of the "MDS 3.0 CAT Specifications" document. The C1000 values involved in triggering are 0, 1, and 2. Values of 3, "-", and "^" are not used in triggering. A value of 3 indicates severe cognitive impairment and is not used in triggering because such severe impairment normally precludes successful rehabilitation therapy.
20110126-009	E-Specs	I have taken a little time to review the two linked documents found under the section "State Required Section S and Additional NQ and NP Items" from the Vendor Call Agenda for January 26, 2011. Within the first document titled "State Section S Items Effective April 1, 2011": • I'm a little confused about New York. We understood before that the field S0520 was going to be used temporarily and replaced with another field April 1. The document for the agenda indicates that there are two new fields and the 6 that were required for October 1, 2010 are all gone. I was expecting only S0520 would be removed. I looked on the New York website and could not find any information about the change for April 1st.	New York has discontinued collecting all items that they began collecting on October 1, 2010 as of March 31, 2011. New York will be collecting the 2 items S0160 and S8055 beginning April 1, 2011. Please continue to check the New York state website for Section S information. WA – The exception to collection of "all CMS items" on the quarterly lists three things not to collect on the quarterly: G0900A G0900B Section V items. As the Q & A from Washington describes, Section V items are not required on the WA quarterly. SD – As with Washington, SD is collecting "all CMS items" on the quarterly except the following: G0900A

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		For the next linked document titled "Additional Items Required by States for Nursing Home MDS 3.0": • The information for Washington indicates that all Section V items should be included and the target date for this was 10/01/2010. We have FAQ document from Washington dated 09/01/2010 indicates that "Section V and the CAAs will not be required on the quarterly". • The information for South Dakota indicates that a full quarterly is required including all Section V items with a target date of 10/01/2010. A website by South Dakota with FAQ makes no mention of a full quarterly being required. As a general question, should we be relying on CMS for the information regarding state requirements concerning Section S and optional questions for NQ and NP or is it best that we perform our own research into the state requirements?	G0900B Section V items. CMS posts the data specifications for the MDS, including section S. CMS can't respond to State specific questions. If you have questions, you should contact the specific State(s).
20110126-011	E-Specs	Questions S0172B through S0172G are listed in the specifications and data dictionary files with an item type of Code. Looking at the Item Values table entries listed in the specifications and data dictionary, however, it would appear that this field was intended to be a checklist. Which is the correct type?	The Section S items that you mention could probably be considered checklist items. However, we probably will not change their item types for two reasons. First, when States submit items for addition to Section S, we typically do not see their data collection forms and therefore deal with the items as discrete entities. With the information provided, it is sometimes difficult to determine what logical connections, if any, there may be among a State's items. Second, and perhaps more importantly, unlike the Federally required items, there are no inter-item edits applied to Section S. Thus, even if a Section S checklist contains a none-of-the above item, we do not enforce the expected logic between the none-of-the-above item and the remaining items on the checklist. Therefore, there is no functional difference on Section S between checklist items and items with type="Code".
20110126-012	E-Specs	This question pertains to the timing of state Section S changes that are scheduled for April 1, 2011. Is the April 1st date based on the submission date or the ARD (A2300) date of the assessment? For example, an assessment is submitted on April 2nd, but has an ARD of March 25th. Should	The new version of the data specs (V1.01) takes effect on 4/1/2011. This means that all submitted records with target dates on or after 4/1/2011 must conform to V1.01. Submitted records with target dates on or before 3/31/2011 must conform to V1.00. Please refer to the new document

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		that assessment follow the "old" (pre-April 1st, 2011) Section S specifications? Or should it follow the "new" (post-April 1st, 2011) Section S specifications? Will software vendors need to support both versions of section S for a state that has made changes? For example, if on April 5th the facility needs to correct an MDS from March 25th, must the vendor bring up the old section S, or is the new one acceptable? Do users get warnings if a Section S question is missing or not marked or would they get a rejection/fatal error message?	("Data specs version summary") that has been posted on the MDS 3.0 technical information web page for details about version control. Only warnings are issued for section S items when item is missing, or the response is missing or invalid.
20110126-014	E-Specs	You mentioned you will change processing of the electronic transmission record to hierarchical. If you encounter a fatal error, will you stop processing at that point and therefore, not return all warnings and error messages?	The caller has misunderstood the change. Edit -3789 should have been a hierarchical edit, but it was not. The new edit (-3810) will determine if an assessment is both a PPS and a Comprehensive; if it is both, the ASAP system will only apply the comprehensive edits – not the PPS edits. The caller should review both edit -3789 and -3810 in the specs. Edit -3810 replaces edit -3789.
20110126-015	E-Specs	In regard to consistency edit -3811, since you're not allowing RFA assessment items, entry date, assessment reference date, and discharge date to be modified, do X0600 and X0700 need to be submitted because they tell whether we are modifying the reason for assessment or date.	Those items are used to find the record. Even though these items can't be changed beginning April 1, they are active on the item subset and need to be completed as they are used to locate the record to be modified/inactivated. CMS will consider whether to revise the ISCs in a later release to remove X0600 and X0700 and have the ASAP system use the corresponding items in Section A. Until a change removing the items from the ISC occurs, the items must be submitted as per the manual and data specification or the modification/inactivation record will be rejected as the record to be modified/inactivated would not be found.
20101220-007	E - Specs	For the xml format, what coding should we use?	ASCII is the character set the ASAP system will accept. This is found in the MDS 3.0 Data Specifications Overview.
20101220-008	E - Specs	I have an assessment that was rejected with the fatal error -3804. Could you please provide information as to why the assessment was rejected?	The values submitted for the end of therapy date items (O0400B6 and O0400C6) are incorrect. <O0400B6>-</O0400B6> <O0400C6>-</O0400C6> The submitted values are a single dash indicating "not

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			assessed" (<O0400B6>-</O0400B6> and <O0400C6>-</O0400C6>). This states that end dates for OT and PT are unknown. The submitted end date for speech (O0400A6) was skipped (value = ^) since there were no speech minutes (O0400A1 through O0400A3). There are no known end dates for therapy and the assessment does not qualify as a special Medicare short-stay assessment which requires at least one therapy having an end date on the Medicare stay end date (A2400C) or therapy is ongoing on the assessment reference date (value = 8 dashes). Rehabilitation classification is based on total minutes of therapy not average minutes of therapy. The total minutes of therapy are less than those required for a therapy group and there are no restorative nursing services so the resident does not classify in a rehab group and the error -3804 occurs because the submitted assessment is a start of therapy OMRA (A0310C = 1) and a rehab/extensive or rehab group does not result. This situation can be fixed by submitting O0400B6 and O0400C6 with 8 dashes instead of 1 dash.
20101220-009	E - Specs	If the tags for an item are sent in, but no value is included or the value is all spaces, what error will occur?	If there is no value or the value is all spaces (not caret, but space), then the record will be rejected with a -1003 Required Field Missing or Invalid or a -1030 Missing Item fatal error depending on which item is missing.
20101220-010	E - Specs	The error message description just noted, 'invalid state code' – value submitted in STATE CD is invalid. Is invalid just determined by the wrong state origination or something else?	The ASAP system will automatically upper case all letters. State cd will be read when submitted as upper, lower, or mixed case (e.g., "TX", "tx", or "Tx"). Error -1008 will trigger if the submitted value is spaces, null or not valid (i.e., not a valid, two-character state code). The valid state codes are listed in the data submission specs for the STATE_CD item. For example, submitting "XY" will cause Error -1008.
20101220-011	E - Specs	What characters can be used in the name item?	The ASAP system supports ASCII encoding only. The data spec has all validation rules defined using printable ASCII characters, any other character in any item will be rejected with validation error. File submitted with non-ASCII special characters will be rejected with -1004 parsing error.

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			The edit on name characters is: -3690 Formatting of Alphanumeric Text Items That Can Contain Dashes, Spaces, and Special Characters: If this item is not equal to one of the special values (if any) that are listed in the Item Values table of the Detailed Data Specifications Report, then it must contain a text string. This text string may contain only the following characters: a) The numeric characters: [0] through [9]. b) The letters [A] through [Z] and [a] through [z]. c) The character [-]. d) The following special characters: [@] (at sign) ['] (single quote) [/] (forward slash) [+] (plus sign) [,] (comma) [.] (period) [_] (underscore) e) Embedded spaces (spaces surrounded by any of the characters listed above). For example, [LEGAL TEXT] would be allowed.
20101220-012	E - Specs	What is the correct format for the electronic file for ongoing dates – or --/--/----? My record is rejected when I submit – or --/--/---- in A2400.	Depending upon the particular date item, the data specs can allow either a single dash ("-") or a string of eight dashes ("--------"). Whether either or both of these values are allowed depend upon the specs for the individual item you're talking about. If you look at the specs for A2400C, you'll see that eight dashes are allowed, but a single dash is not. If you look at O0400B5, you'll see that a single dash is allowed, but eight dashes are not. Finally, if you look at O0400B6, you'll see that either a single dash or eight dashes are allowed. The general rule for these date items is that a single dash is used to indicate that the item was not assessed or that information was not available. The use of eight dashes is generally reserved for special meanings. For example, for O0400B6, eight dashes indicate that therapy is ongoing. The use of slashes (e.g., "--/--/----") would not be allowed

ID	Topic	Question	Answer
			for two reasons: (a) they exceed the maximum length of 8 characters, and (b) they are not in YYYYMMDD format The use of – (not assessed) is not a valid value for A2400. If ongoing dates are needed, then the data specifications require a string of eight dashes ("--------") for A2400.
20101101-015	E - Specs	On the NQ and NP forms, O0400D2, days of respiratory therapy, and O0400E2, days of psychological therapy are both active. The CMS specifications include this skip pattern – a) If O0400D1=[0001-9999], then if O0400D2 is active it must not equal [^]. b) If O0400D1=[0000], then if O0400D2 is active it must equal [^]. c) If O0400D1=[-], then if O0400D2 is active it must equal [-]. a) If O0400E1=[0001-9999], then if O0400E2 is active it must not equal [^]. b) If O0400E1=[0000], then if O0400E2 is active it must equal [^]. c) If O0400E1=[-], then if O0400E2 is active it must equal [-]. O0400D1 and O0400E1 are inactive on all forms except the NC. With O0400D1 and O0400E1 inactive on the NQ you will never have minutes which means item B in the skip pattern is active and O0400D2 and/or O0400E2 must equal ^. Why have the fields on the NQ if they are always a caret based on the CMS skip pattern? CMS specifications do not breakdown by MDS form type except for Active\Inactive. The instructions on the MDS for D2 and E2 plainly state "record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days." Maybe the minutes for respiratory and psychological are not needed but that does not help the skip pattern in CMS specifications. There is a related fatal error as well– O0400D1 must be greater than or equal to O0400D2*15. O0400E1 must be greater than or equal to O0400E2*15.	The answer to this question can be found on page 10 of the data specifications overview document (MDS 3.0 data specs overview (v1.00.3) 06-01-2010.pdf). Towards the bottom of the page, the document says the following: "The relational edits that are included in the data specifications apply only to items that are active for a particular item subset. Items that are not active on a particular item subset should not be submitted and are not edited even if they are submitted. For example, consider an edit that says "If Item A=[1], then all active Items B, C, and D must equal [2]". If Item A was equal to [1], then any of the items B, C, and D that were active must equal [2]. However, if any of these three items (e.g., Item B) was inactive, it would not be submitted, would not have a value, and would not be edited. The edit would therefore not apply to the inactive item but would continue to apply to the remaining active items, if any. Similarly, if Item A was not active, the entire edit would not apply." Let's use respiratory therapy (O0400D) as an example. On an NC, both O0400D1 (minutes) and O0400D2 (days) are active. Therefore, Edit -3560 (which deals with the skip pattern) and Edit -3699 (which describes the mathematical relationship between days and minutes) both apply. However, on an NQ, only the "days" item is active. Therefore, both of these edits are suspended. The only remaining rules for the "days" item are the formatting rules and the allowable range of values. Thus, the days item would not always be skipped on an NP or NQ, as was stated in the question.
20101101-014	E - Specs	For a PPS assessment (NP) where Z1 is not there (it is not on the print), how is O0100 A1 - Z1 coded if the assessment is done within the first 13 days?	On an NP being completed within the 14 day lookback period, O100A1 - O100J1 would be assessed individually and only checked (code value 1) if the treatment occurred

ID	Topic	Question	Answer
			prior to admission/reentry to the facility and within the 14 day lookback period. If the item is assessed and it is determined that the treatment did not occur prior to admission and within the 14 day lookback period, then the item then is not checked (code value 0). The item O0100Z1 is not active on an NP so it is not answered. Not answering O0100Z1 does not affect the answers to O100A1 - O100J1. The values in the items O0100A1 - O0100J1 are coded per the 1.00.3 data specifications.
20101101-013	E - Specs	For the Item Set - NT - for Entry and Death in the Facility Records - what fields are required? The item set posted by CMS includes Item Z0400, which is the signature with attestation; however, the Submission Specifications on the CMS website list Section Z as inactive for version 1.00.3. What should be included on the NT assessment? Where should I be looking to see what items are included with each Item Set?	The data submission specifications (V1.00.3) contain a table called ITM_MSTR (both in the Access database and as a CSV file) which indicates which items are active for each item subset code. However, keep in mind that this table includes only those items that are submitted to the ASAP system. There are a few additional items on the printable item sets that must be completed even though they aren't submitted. This includes Z0400 (the signature items). These signature items must be completed on an NT record which is why they're included on the NT printable item set. To summarize: The data submission specifications are the correct source to determine which items must be submitted for each item subset code. The printable items sets are the correct source for determining which items must be completed for each item subset (i.e., the printable item sets include all submitted items plus a few non-submitted items).
20101101-012	E - Specs	A0310E Is this assessment the first assessment (OBRA, PPS, or Discharge) since the most recent admission? This is a new concept and is important since the item controls whether certain clinical items are addressed or not on the current assessment. A special transition rule applies to the first assessment under MDS 3.0 for each resident. *The first MDS 3.0 assessment should have A0310E coded as 1. Yes*, (indicating that this is the first MDS 3.0 assessment), whether or not there was a prior MDS 2.0 assessment before 10/01/2010. Is the above applicable to entry tracking records?	The item A0310E is never coded as 1 for an entry tracking record or a death in facility tracking record. It is only coded 1 for an OBRA, PPS, or discharge assessment. With the transition to MDS 3.0, A0310E is coded 1 on the first MDS 3.0 OBRA, PPS, or discharge assessment. If the first MDS 3.0 record is an entry, this record will be coded 0 on A0310E. When the first MDS 3.0 OBRA, PPS, or discharge assessment subsequently occurs, that record will be coded with A0310E = 1 per the special transition rule. After that, the coding of A0310E follows the normal rules.
20101101-011	E - Specs	Answer sets for Question A0410 Background: The verbiage from the data submission specifications for all three possible answers leads the user to	Providers need to identify the submission requirement for each record. The specifications list the 3 possible values.

ID	Topic	Question	Answer
		not choose answer #1. A0410 - Submission requirement -3707 Fatal Consistency: a) If A0200=[2] (if the provider is a swing bed provider), then A0410 (submission requirement) must equal [3] (it cannot equal [1,2]). b) If A0200=[1] (the provider is a nursing home), then A0410 must equal [2,3]. c) For both nursing homes and swing bed providers, A0410 must not be equal to [1]. However, when reviewing the coding instructions from the RAI manual regarding this question, it says that there are times when users should code the question as a 1: Code 1, neither Federal nor State required submission: if the MDS record is for a resident on a unit that is neither Medicare nor Medicaid certified, and the State does not have authority to collect MDS information for residents on this unit. Question: Can you please clarify how to answer this question? For example, should users always choose answer 2 to 3?	A0410 = 3: CMS only has System of Record (SOR) authority to access those records with a submission requirement value = 3. A record with A0410 = 3 will be edited by the ASAP system, and if no fatal errors occur, will accept the record and store it in the ASAP system. CMS will have access to the record. A0410 = 2: Some states have a law that allows them to collect MDS assessments on licensed only beds. The authority is the submission requirement value = 2. CMS cannot access these records, only the state can access these records. States with these laws must set a parameter in the ASAP system indicating that they have a law that allows them to collect. When the ASAP system receives a record with an A0410 = 2, the ASAP system checks to see if the state of the record has set their authority to collect submission requirement = 2 records indicator to Y. If the state has set their indicator to Y, then the record will be edited by the ASAP system and if no fatal errors occur, will accept the record and store it in the ASAP system. The state will have access to the record. CMS will NOT have access to the record. Records with a submission requirement = 2 should only be transmitted for states with a law to transmit. Records with a submission requirement = 2 in states with their indicator set to N will be cleared out from the submitted file and not edited and not stored. No personal identification from the record is stored nor returned on the validation report. The record will receive a message -3658 - No Authority to Collect Data: Privacy rights require federal and/or state authority to collect MDS data. There is no authority to collect the data submitted. Data was not accepted. A0410 = 1: These records do not fall under any law to transmit so should NOT be submitted to the ASAP system. Records with A0410 = 1 are usually completed for some other purpose (i.e. insurance requirement). If a record with A0410 = 1 is submitted, it will be cleared out from the submitted file and not edited and not stored.

ID	Topic	Question	Answer
			No personal identification from the record is stored nor returned on the validation report. The record will receive a message -3658 - No Authority to Collect Data: Privacy rights require federal and/or state authority to collect MDS data. There is no authority to collect the data submitted. Data was not accepted.
20101101-010	E - Specs	How are dates supposed to be submitted when they are unknown or ongoing (-)?	Dates must be submitted based on the submission specifications for the particular date item and instructions from the MDS 3.0 RAI Manual. Depending upon the particular date fields, the data specs can allow either a single dash ("-") or a string of eight dashes ("--------"). Whether either or both of these values are allowed depend upon the specs for the individual item you're talking about. If you look at the specs for A2400C, you'll see that eight dashes are allowed, but a single dash is not. If you look at O0400B5, you'll see that a single dash is allowed, but eight dashes are not. Finally, if you look at O0400B6, you'll see that either a single dash or eight dashes are allowed. The general rule for these date items is that a single dash is used the same way as on most other items -- to indicate that the item was not assessed or that information was not available. The use of eight dashes is generally reserved for special meanings. For example, for O0400B6, eight dashes indicate that therapy is ongoing.
20101101-007	E - Specs	Nursing facilities in Pennsylvania are instructed by the State to skip S9080C (Recipient number) and S9080D (MA NF Effective Date) if the resident is not MA for MA Case Mix (S9080A=0.No), The CMS Data Dictionary does not indicate that a skip (^) or dash value is valid for these items. Pennsylvania is instructing vendors to allow a dash for these items, as well as for S0120 ZIP Code of Prior Primary Residence and S0123 County Code of Prior Primary Residence if unknown. My questions are: If our software allows the user to enter a dash for Pennsylvania's Section S items, will the record be rejected? Instead of a dash, should a skip (^) value be placed into the XML for items that should be skipped? What value should we place in the XML file for skipped and/or unknown items within Section S?	It is correct that the CMS Data Dictionary does not indicate that a skip or dash value is valid for these. For any Section S item, if a value is submitted that is not listed as a valid value, Edit -3808 is triggered and a warning is issued; however, this warning does not cause rejection of the record. If a Section S item has a value sent that is NOT in the list of valid values for that item, the value is NOT stored in the database. The value in the database for the item is null.
20101101-006	E -	Is there a standard as to where Section S items should be	There is no order requirement for items on the submitted

ID	Topic	Question	Answer
	Specs	submitted on an xml file? Should the items be submitted in alphabetical order or should Section S be after Section Z?	XML records. The items in the XML file can be submitted in any order. As long as all the items active on the ISC are submitted, the order doesn't matter.
20101101-005	E - Specs	I have a couple of minor questions I need clarification on. We have poured over the specifications but need help on these items please. ORIGINAL_ASSESSMENT_ID SUBMITTING_USER_ID SUBMISSION_DATE SUBMISSION_COMPLETE_DATE RESIDENT_MATCH_CRITERIA STATE_EXTRACT_FILE_ID CMI_SET_FOR_RECALC_Z0100A CALCULATED_ITEMS_FILLER1	All items cited are calculated items. All calculated items are calculated and stored in by the ASAP software when appropriate. Calculated items (item type is CALC) are NOT submitted in any XML submission record.
20101101-004	E - Specs	Are there additional fields that will be submitted on an xml file after Section Z? The sample xml files do not show any fields after Section Z. Examples of additional fields are: RECALCULATED_Z0100B RECALCULATED_Z0100C RECALCULATED_Z0150A	The items designated as calculated (described in the MDS 3.0 Data Specifications in the Detailed Data specs report) are calculated by the ASAP system. They are not submitted in an XML submission record.
20100926-014	E - Specs	Q1. What is the acronym ISC? Q2. What is the isc_mstr table a key of? The types of assessments that can be submitted to CMS? Q3. Is the isc_val table a reflection of the actual assessments that can be submitted? Example 1: isc_id_key 2 has an isc_id indicating '--' which means Invalid ISC (RFA combination not allowed). Is this type of assessment an error that gets kicked back to the facility for correction or is it accepted? Example 2: isc_id_key 225 has an isc_id indicating 'NC' which means Nursing home: comprehensive assessment. This assessment indicates an Admission (A0310A) with a Discharge return not anticipated (A0310F). I would expect to see a discharge be submitted with either the A0310A set to 99 or be blank. Why would an admission assessment be marked along with a discharge? Q4. Will the two discharge types (return anticipated and return not anticipated) be submitted with all different types of assessment codes? Q5. On this table (isc_val), why isn't an example of a re-entry listed? How will a re-entry be submitted to CMS?	A1. Item subset code. The ISC is based upon the reasons for assessment (A0310A, B, C, D, and F) and indicates the type of record and the items that are active on the record. A2. Yes, this is a list of the valid ISCs. A3. A record with an invalid combination of reasons for assessment will produce a fatal error and, like any record with a fatal error, will be rejected by the ASAP system. A4. When determining the ISC, the two discharge types (A0310F=10 [return anticipated], and A0310F=11 [return not anticipated]) are treated identically. If you look at the ISC_VAL table, you will see that both of these types of assessment will produce a "D" (discharge) in the ISC code. A5. Scenario 1 - This is the correct re-entry reasons for assessment for a nursing home re-entry tracking record which has an ISC = NT or a swing bed re-entry tracking record which has an ISC = ST. A0310A = 99 (Not OBRA required)

ID	Topic	Question	Answer
		Scenario 1 A0310A = 99 (Not OBRA required) A0310F = 01 (Entry Record) A1600 = date of entry A1700 = 2 (reentry) Scenario 2 A0310A = blank A0310F = 01 (Entry Record) A1600 = date of entry A1700 = 2 (reentry) Scenario 3 A0310A = 01 (Admission) A0310F = 01 (Entry Record) A1600 = date of entry A1700 = 2 (reentry)	A0310F = 01 (Entry Record) A1600 = date of entry A1700 = 2 (reentry)
20100926-013	E - Specs	I am working on developing training for my staff during the transition process, do you have a sample copy of the Final Validation report, one that contains both the RUG-III and RUG-IV codes. This will be very helpful in helping identify where these will show-up on the report.	Following the implementation of the QIES ASAP MDS 3.0 system, a RUG-III value will be provided on the Final Validation Report for records submitted with a target date between 10/01/2010 and 10/31/2010 (inclusive) with the exception of records where A0310A = 99 and A0310B = 99. Providers will see this information displayed in Warning message -1057 Medicare RUG III Transition RUG Calculated: A Medicare Transition RUG III was calculated for this assessment. This information can also be located in Section 5 of the MDS 3.0 Providers User's Guide which is available on the QTSO website (www.qtso.com/mds30.html). This manual would be helpful for training.
20100926-012	E - Specs	Section N on the NQ set doesn't have a Z - None of the Above - Is this an oversight? It has the None of the Above on the NC set.	There are several other items on different MDS 3.0 item sets where a None of Above item is not active or is missing from the item listing. This was intentional as the definition of the None of the Above depends on what items are in the list. In the cases where the None of the Above item is active on the NC and not active on the NQ, the NQ does

ID	Topic	Question	Answer
			not contain all of the items in the list. The item list referred to in Section N is N0400A - G and N0400Z (None of the Above). In the item set N0400Z is defined as not having N0400A - N0400G. On the quarterly, only N0400A - N0400D are active and N0400E - N0400G are not active. For the quarterly, a None of the Above item would be defined as referring to N0400A - N0400D. If N0400Z was used, then this is a different definition of the same item. If states choose to add all three items N0400E - N0400G to their NQ or NP assessments as state optional fields, then they can also add N0400Z as all the items in the list will be active so the None of the Above will have the correct meaning. The ASAP system will only edit a checklist if all possible items are active within that checklist.
20100926-011	E - Specs	The tracking forms, Entry and Death in Facility, do not have an A2300 or a Z0500B date required on the form, will the CMS system calculate either a target date or an effective date for either of these forms?	CMS will calculate a target date for all records except for inactivation requests based on the MDS 3.0 Data Specifications. The target date is defined in the MDS 3.0 Data Specifications under edits -3658 and -3762 as well as under information -9017 under target date in the Calc section. The calculated effective_date is not calculated and will always be blank filled. See information -9018 under effective_date in the Calc section of the MDS 3.0 Data Specifications
20100926-009	E - Specs	Has a decision been made regarding Edit ID -3781? Are X1100C and X1100C required as is implied in the edit ID? If X1100C and X1100D are required when X0100 = [1, 2], is the Item Type text?	X1100C and X1100D (attesting individual's title and signature) are not submitted items and are therefore never active items on any of the MDS 3.0 item sets. Edit -3781 refers to *all active items* from X1100A through X1100E. Since X1100C and X1100D are never active, the edit does not apply to them.
20100820-031	E - Specs	I printed 2 documents that show examples of the validation reports. They list some warning numbers (-1054, -1055, -1056) that I have not been able to locate. Can you give me some direction on where to find the specifications for those?	The system error codes are available in Section 5 of the MDS 3.0 Provider's User Guide. The guide is posted under the MDS 3.0 link on the QTSO website.
20100820-012	E - Specs	We are working to create a rule to auto populate this section of the MDS from our Immunizations module. The current instructions for this for manual coding are:	When the flu vaccination items (O0250A-C) are active on an assessment, they should always be answered and they should be answered with regard to the ongoing or most recent flu season. The relevant flu season should be determined using the ARD for the assessment. In the

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		Coding Instructions for O0250A, Did the Resident Receive the Influenza Vaccine in This Facility for This Year's Influenza Season? Code 0, no: if the resident did NOT receive the influenza vaccine in this facility during this year's Influenza season. Proceed to If Influenza vaccine not received, state reason (O0250C). Code 1, yes: if the resident did receive the influenza vaccine in this facility during this year's Influenza season. Continue to Date Vaccine Received (O0250B). Example: Mrs. J. received the influenza vaccine in the facility during this year's Influenza season, on January 7, 2010. Coding: O0250A would be coded 1, yes; O0250B would be coded 01-07-2010, and O0250C would be skipped. We need to know if this coding is based on the ARD of the assessment. Does the ARD have to be within the date range for the influenza season? For example, if flu season is 10/01/2010 to 05/15/2011 and the ARD is set as 05/20/2011, does this get answered since the ARD is outside of the flu season or does this always get answered based on the most recent flu season information?	example given in the question, if the ARD was 5/20/2011, the items should be answered with regard to the flu 2010/2011 flu season. Please note that in the recently-posted errata document for the MDS 3.0 data submission specifications (dated 7/20/2010), issue #11 explains that Edit -3762 is being suspended until further notice. This edit governs item O0250B (the flu vaccination date). The purpose of the edit is to make sure that the vaccination date falls within the proper flu season, but this edit will not be applied by the ASAP system when the system starts up in October. The edit may be reinstated at a later time, however.
20100820-010	E - Specs	We found a problem with the logic for edit -3527 sub edit a) Currently it states that IF C0100 = [0, ^], then all active items from C0200 through C0600 must equal [^]. This causes C0600 to be skipped when C0100 is skipped which triggers the skips for C0600 as well. The logic for -3527 sub edit a) should be If C0100 = [0, ^], then all active items from C0200 through C0500 must equal [^]. This way C0600 is not skipped incorrectly.	The specs are correct. C0600 in this circumstance is skipped correctly. The filling out of the staff assessment when C0600 is blank is covered under -3528d. CMS did not want to have the assessor complete the staff interview gateway question (C0600) when they already knew based on C0100 that they did not complete the resident interview so the staff must complete C0700 - C1000. -3528 Consistency Fatal a) If C0600 = [0], then all active items from C0700 through C1000 must equal [^]. b) If C0600 = [1], then all active items from C0700 through C1000 must not equal [^].

ID	Topic	Question	Answer
			c) If C0600 = [-], then all active items from C0700 through C1000 must equal [-]. d) If C0600 = [^] and C0100 = [0], then all active items from C0700 through C1000 must not equal [^].
20100820-006	E - Specs	If A0310A is 05 or 06 will it be a fatal error if A2200 is less than 10/1/2010?	No, there is no edit that compares A2200 with October 1, 2010.
20100720-054	E - Specs	I am not able to locate the CAT20_test_v2.txt in order to test CAT20.	The CAT Specification Package V1.00.3 does contain the wrong CAT 20 test data file. The file "CAT20_test_v1.txt" is contained in the V1.00.3 package but the file "CAT20_test_v2.txt" should have been included. The file "CAT20_test_v1.txt" has test data appropriate to an old definition for CAT 20 triggering. The "CAT20_test_v2.txt" is available in the V1.00.3 package. A brief document describing this change has been added to the package.
20100720-047	E - Specs	How will the assessment internal ids be assigned? Will you re-use any numbers previously used in MDS 2.0, or will the numbering scheme be totally different? We need to find this out in order to design the database.	A new sequence will be used for the MDS 3.0 assessment IDs. This sequence will be for all MDS 3.0 records submitted from all states, both NH and SB. Each MDS 3.0 Assessment ID will be unique. An MDS 3.0 assessment id may have the same value (number) as an MDS 2.0 assessment_internal_id in one or more states.
20100720-037	E - Specs	Will there be a batch upload capability?	For MDS 3.0 submissions, multiple XML records can be zipped together into a single zip file so long as the zip file is less than 5 megabytes. Even if only a single .XML assessment is to be submitted, it must be zipped into a compressed zip file. The information on creating a zip file is located in the MDS 3.0 Data Specifications overview.
20100720-015	E - Specs	Do you have any specs for the xml schema's documented yet? I saw the sample xml documents but I am looking for the .xsd's.	CMS is not supplying XSD's for the XML files, only the MDS 3.0 Data Specifications. You can get more information on the data specifications and XML schemas on http://www.cms.gov/NursingHomeQualityInits/30_NHQIMDS30TechnicalInformation.asp#TopOfPage.
20100720-009	E - Specs	A question has come up about the first MDS 3.0 OBRA assessment's due date. For example an OBRA quarterly is completed on 9/1/2010 but has an ARD of 8/29/2010, MDS 2.0 would set the due date of the next quarterly based on the completion date of 9/1/2010. With MDS 3.0 changing the due date calculation from the completion date to the ARD of the	1. If the ARD is on or before 9/30/2010, then an MDS 2.0 must be completed. 2. If the ARD is on or after 10/1/2010, then an MDS 3.0 must be completed.

<table>
<tr><th>ID</th><th>Topic</th><th>Question</th><th>Answer</th></tr>
<tr><td></td><td></td><td>previous assessment, there could be small window of overdue OBRA assessments.
Will there be a grace period on the due date of the first MDS 3.0 OBRA assessments or will software developers need to readjust the first MDS 3.0 OBRA schedule due dates based on the ARD of the last MDS 2.0 OBRA assessments?</td><td>3. Yearly timing rule (applies if the submitted MDS 3.0 record is a comprehensive assessment):
a) If the most recent prior comprehensive assessment is an MDS 3.0, then the ARD of the new MDS 3.0 assessment must be within 366 days of the ARD of the prior assessment.
b) If the most recent prior comprehensive assessment is an MDS 2.0, then the ARD of the new MDS 3.0 assessment must be within 366 days of the VB2 date of the prior assessment.

4. Quarterly timing rule (applies if the submitted MDS 3.0 record is a quarterly or comprehensive):
a) If the most recent prior quarterly or comprehensive assessment is an MDS 3.0, then the ARD of the new MDS 3.0 assessment must be within 92 days of the ARD of the prior assessment.
b) If the most recent prior quarterly or comprehensive assessment is an MDS 2.0, then the ARD of the new MDS 3.0 assessment must be within 92 days of the R2B date of the prior assessment.

5. The yearly and quarterly timing rules apply only to nursing home assessments. These rules are not applied to swing-bed assessments.

6. If a submitted assessment fails either the yearly or quarterly timing rules, warnings will be issued, but the record will be accepted (unless it has other fatal errors). The timing rules are not fatal edits.</td></tr>
<tr><td>20100720-008</td><td>E - Specs</td><td>For these MDS 2.0 fields, can you please indicate whether these fields are still present in MDS 3.0 and where they are located?
ASSESSMENT_INTERNAL_ID
FACILITY_INTERNAL_ID
SUBMISSION_SEQ_NUMBER
AA8A
AA8B
EFFECTIVE_DATE
TARGET_DATE
CREATED_DATE
UPDATED_DATE</td><td>
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<tr><th>MDS 2.0 Assessment Table Field Name</th><th>Format</th><th>MDS 3.0 Data Specification Section</th><th>MDS 3.0 Data Specifications Item ID</th></tr>
<tr><td>ASSESSMENT_INTERNAL_ID</td><td>Number (10)</td><td>Calc</td><td>ASSESSMENT_ID</td></tr>
<tr><td>FACILITY_INTERNAL_ID</td><td>Number (10)</td><td>Calc</td><td>FACILITY_PROVIDER_IN</td></tr>
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ID	Topic	Question	Answer			
		RES_CHG_TIMESTAMP RES_MATCH_CRITERIA QI_IS_VALID RESIDENT_INTERNAL_ID ORIG_ASMT_INT_ID AST_BEG_VER_DT AST_END_VER_DT AST_MOD_IND AST_CORR_VER				TERNAL_ID
			SUBMISSION_SEQ_NUMBER	Number (10)	Calc	SUBMISSION_ID
			AA8A	Char (2)	A	use A0310A - A0310F
			AA8B	Char (1)	A	use A0310A - A0310F
			EFFECTIVE_DATE	Char (8)	Calc	EFFECTIVE_DATE - always blank/not calculated
			TARGET_DATE	Char (8)	Calc	TARGET_DATE
			CREATED_DATE	Char (8)		not in MDS 3.0
			UPDATED_DATE	Char (8)		not in MDS 3.0
			RES_CHG_TIMESTAMP			not available on state extract file
			RES_MATCH_CRITERIA	Number (2)	Calc	RESIDENT_MATCH_CRITERIA
			QI_IS_VALID			not in MDS 3.0
			RESIDENT_INTERNAL_ID	Number (10)	Calc	RESIDENT_INTERNAL_ID
			ORIG_ASMT_INT_ID	Number	Calc	ORIGINAL_ASSESSMEN

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<tr><th>ID</th><th>Topic</th><th>Question</th><th>Answer</th></tr>
<tr><td></td><td></td><td></td><td>
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<tr><td></td><td>(10)</td><td></td><td>T_ID</td></tr>
<tr><td>AST_BEG_VER_DT</td><td>Char (8)</td><td>Calc</td><td>use SUBMISSION_DATE</td></tr>
<tr><td>AST_END_VER_DT</td><td>Char (8)</td><td>Calc</td><td>use SUBMISSION_DATE of the next modification or inactivation for this assessment</td></tr>
<tr><td>AST_MOD_IND</td><td>Char (1)</td><td>X</td><td>use A0050</td></tr>
<tr><td>AST_CORR_VER</td><td>Number (2)</td><td>X</td><td>use X0800</td></tr>
</table>
</td></tr>
<tr><td>20100420-AdHoc11</td><td>E - Specs</td><td>Is A2400, Medicare start of stay, a required field that has to be entered? Will that date (whatever the date is), be entered for each assessment until such time as the stay ends?</td><td>The answer to both questions is yes. It is a required on all types of assessments, except on an inactivation. Yes, continue to enter it during the course of the stay. You indicate the start and end date of most recent Medicare coverage stay.</td></tr>
<tr><td>20100420-AdHoc09</td><td>E - Specs</td><td>My question regards answer 00013 from the January 14 conference. It stated the calculated items will be populated in files received from CMS. What files is this statement talking about?</td><td>In the data specs, there is a layout for a flat file which will be used by CMS to produce extract files for the states. The layout for Section S has just been added to version 1.00.2 of the data specs, which will be posted in the near future. On the layout, there are calculated fields. The ASAP system will recalculate some items are recalculated without storing the recalculated value in the database. An example of such an item is the recalculated PHQ (D0300, D0600). If the assessment does not have the correct calculated PHQ score, the ASAP system issues a fatal error so the record is rejected. If the recalculated PHQ value equals the submitted value then there is no need to store it as they are the same. Another calculated field the ASAP system stores is the urban/rural flag which is looked up for use in calculating the RUG/HIPPS group.</td></tr>
<tr><td>20100420-38</td><td>E - Specs</td><td>If F0300= [0], then all active items from F0400A through F0700 must equal [^]. For similar sections (Section C,</td><td>The only way that F0300 will equal [^] (skipped) will be if B0100=[1] (if the resident is comatose). This case is</td></tr>
</table>

ID	Topic	Question	Answer
		Section D), the rule also includes ^. Just want to clarify if this should be [0, ^] or just [0].	handled by Edit -3609.
20100420-37	E - Specs	Where can I find a listing of the items that are included on the different MDS assessment types - like Discharge Assessment, Quarterly Assessment, PPS only assessment, etc?	Go to http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html website, download the current version of the MDS 3.0 Data Submission Specifications, Open the data specs CSV files zip file. The information is in the itm-sbst .csv file. It has a title row of all the item subsets (abbreviated) and a column with all of the item names. There is an 'x' at the intersection of item row and ISC column which indicates that item is in that ISC.
20100420-33	E - Specs	Is there a specific program that we need to use to create the zip submission file?	The MDS 3.0 submission system uses a Java stored procedure to unzip the submission files. The utility is implemented using the Java 1.5.0_11-b03 Java virtual machine included with the Oracle database. The Java utility class is called JAVA.UTIL.ZIP. Although we have not been able to find a specific listing of support for other zipping tools, we found recommendations to use normal PKZIP and WINZIP applications. There are many ZIP programs on the market and many of them have added their own proprietary 'SUPER COMPRESSION' which will NOT be supported by the submission system. Developers can also use the JAVA.UTIL.ZIP class to ZIP their own files. The class files can be found in the Sun JVM. We believe the implementation is the same across the different versions of Java. Developers should consult their Sun Java documentation for specifics. Yesterday, we completed a test using the Microsoft Folder Compression. The submission was successfully unzipped with 3 files for processing. According to Microsoft, their folder compression comes in 2 flavors based on the FAT32 or NTFS file system. We tested with NTFS. Microsoft says the folder compression creates a compliant ZIP file. We were able to successfully unzip the file created with the MS

ID	Topic	Question	Answer
			Folder Compression using WinZip. Microsoft added one caveat with respect to its use. The Folder Compression is meant to be used from the OS. Microsoft does not provide any means to call this compression from any other program. Do not zip the individual records before including them in the final zip file.
20100420-28	E - Specs	When will .ZIP sample files be available?	We have no plans on publishing a sample .zip file.
20100420-25	E - Specs	Will CMS work on changing the format (of XML) to allow multiple assessments per XML file?	Not at this time. We will accept a .zip file with multiple XML files from multiple vendors from multiple states.
20100420-19	E - Specs	I'm looking for a document that contains a title and brief description of each required field for the Long Term Care MDS guidelines. I'd like to verify that an application we sell will meet the MDS guidelines, and be able to map fields from our application to your data submission guidelines.	The website http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.htmlcontains all public documentation for MDS 3.0. The link at the bottom of the page for the most current MDS 3.0 Submission Specs) would be most useful. There are several zipped files that contain item descriptions, field lengths, data types as well as all the edits for each field. The information is written in a variety of formats that you might find useful. There are .pdf files, CSV files, .mdb files, and text files. You will see that the same information is in a variety of formats, hopefully to accommodate your particular preference in digesting the information. I hope this answers your question. I've added you to the vendor list as well. Periodically there are vendor conference calls where vendors have submitted questions for us to answer as they do their development. The questions and answers from our two calls for MDS 3.0 can be found on the public web site www.qtso.com under the 'Vendors' link.
20100420-17	E - Specs	Also, I know the data specs have been updated – do you plan to update the data dictionary as well? Will that be updated on a given schedule or just as you have time?	The current version of the MDS 3.0 Data Submission Specifications are posted on the CMS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html.
20100420-07	E - Specs	If question F0300 is 0, all active items from F0400A-F0700 are to be blank as per the -3533 edit. Looking at edit -3534, there is no handling F0700 being a blank value. Is it safe to assume that if F0300 = 0, and F0700 = blank, that F0800A-	The intent is that if F0300=[0], then F0400 through F0700 must be skipped (equal to [^]) and F0800 must be completed (not equal to [^]). The edits are correct in the MDS 3.0 Submission Specifications, which are available on

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		F0800Z must be answered?	the MDS 3.0 Technical Information page on the CMS website.
20100225-085	E - Specs	What is the FAC_ID (Assigned facility/provider submission ID) and how is it obtained? Is this the same value as the MDS 2.0 FAC_ID?	The fac_id is the same fac_id as for MDS 2.0. It is the state assigned facility identifier.
20100225-080	E - Specs	Since the Inactivation has active items for sections A and X only, can we expect an Item Subset document that includes only those 2 sections?	No. There will not be an Item subset for an inactivation. Inactivation records only have control items and Section X items active. There are no active Section A items for an inactivation.
20100225-069	E - Specs	Question A1500 Resident Evaluated by PASARR data specs indicate it's active on NC,NQ,NP,NSD,NOD,ND,SP,SSD,SOD,SD ISC's and inactive on NS,NO,NT,SS,SO,ST,XX record types. Since edit -3777 indicates: a) If A0310A=[01], then if A1500 is active it must not equal [^]. b) If A0310A=[02,03,04,05,06,99], then if A1500 is active it must equal [^]. Why is this field active on any record type other than an NC since it's only completed on an admission assessment? All other active ISC's will be submitted as blanks all the time, correct?	It is true that some items in Section A are skipped for some types of records. However, because most Section A items are required for every type of record (except inactivations), we made a design decision to make all Section A items active for all of these types of records and to use skip logic to exclude individual items when necessary. This decision decreased the number of printable item sets and ISCs that would otherwise be required.
20100225-068	E - Specs	NQ Skip Patterns Question • H0200C is skipped if H0200A = [0,-]. H0200A is inactive on a quarterly. Do we assume that the skip pattern is not active and H0200C should be answered? NQ Edit Checks On a NQ, O0400D1 is inactive and O0400D2 is active. Do we assume that we can ignore consistency rules concerning these two fields if one is inactive?	Because H0200A is inactive on a quarterly, any edits that involve H0200A do not apply to quarterlies. Therefore, edit -3537 would not apply and any of the valid values listed (including [^]) could be submitted. Similarly, because O0400D1 is inactive on quarterlies, edits involving O0400D1 would not apply on quarterlies.
20100225-062	E - Specs	Edit id – 3573, in the Group A Rules, there is an entry "**A2300 (assessment reference date) = A2000 (discharge date)"** that I don't fully understand. What logic does the "=" stand for in this case? Does the "=" mean that the ARD should be the same as the Discharge date?	If the discharge record is combined with another assessment that requires an ARD to be entered, then the discharge date (A2000) must be the same date as the ARD (A2300). Two assessments may not be combined into one record if they have two different target dates. Hence if submitted in the same record and both dates are not skipped [^], they must be equal.
20100225-059	E - Specs	Is there a control field in MDS 3.0 that replaces the file_dt field from the MDS 2.0 header record?	No.
20100225-054	E - Specs	Will section X of MDS 3.0 be used in the same way as the MDS 2.0 prior section, so that MDS 3.0 section A contains	Yes. Section X is used to identify the Type of Record in X0100 (add, modify, inactivate) and to identify the record to

ID	Topic	Question	Answer
		the new data for the assessment and section X is only used to identify the assessment for which to modify or inactivate?	be modified/inactivated (X0100 = [2,3]) and the reasons for this modification/inactivation. The information in Section A on a modification record (X0100 = 2) is the new information for the modification.
20100225-050	E - Specs	There is a short list of 9000 series "informational" edits in the specs. Some of these imply that a possible edit could be in place. Are these part of the standard "validation" edits or are these not included in the validation process.	They are informational only and are not included in the MDS 3.0 submission system edits or messages.
20100225-030	E - Specs	I am requesting clarification on edit -3573 as of the 01/11/2010 specs. I have a couple of issues regarding the recent updates to this edit. One of the updates involved the additional constraint on rule 2 which states "if a2300 is active." My issues are: · The verbiage under group A "Group A items are listed below. Each active item in this list that contains a valid date…" to me already implies that a2300 must be active. · I am also assuming that a0900 must be active as well given the verbiage in my point above, however rule 1 does not explicitly state this. So which is accurate? · There is no mention of whether the logic in rule 3 using a0310f should run if a0310f is active. Edit -3573 will run for an XX ISC and a0310f will not be active.	The date relation edits are only applied to date fields that are active on the ISC. This is an edit which compares dates within a single record for consistency. Only dates that are active are edited. If a date is not active (such as A2300 on an ISC of NT), then that date is not edited for that ISC. The same is true for the other dates. A0900 - birth date is only edited on ISC's where the birth date is active. If the birth date is not active as on an ISC = XX (Inactivation), then the birth date is not edited. For the issue in the third bullet, since A0310F is not active on and XX ISC (inactivation), then edit #3 will not apply. For an inactivation, the only field in the Group A and Group B lists of dates that is active is X1100E so the only edit that will run is that X1100E (correction: attestation date) <= current date where the MDS 3.0 Assessment Submission and Processing System uses the submission date as the current date of the assessment for this edit.
20100225-029	E - Specs	The specs for the item a0500b (resident middle initial) has a maximum length of 1. Edit -3691 says that if a0500b is not a special value (^) that it must only the following characters. These characters are listed below. What middle initial would be a number or one of the special characters? o 0-9 o a-z o A-Z o @ o ‘ o / o . o , o + o _	CMS has decided to leave this edit unchanged. Vendors are free to enforce a more restrictive edit on this item if they wish.
20100225-027	E -	Why does the isc_val database table include entries for the	The isc_val table includes all possible combinations of the

ID	Topic	Question	Answer
	Specs	ISC of '—'which is invalid? The pseudo code assumes that all other combinations are to be assigned '—'so why have these entries? The isc_val table contains values for a0200 which are not allowed, specifically ^. The isc_val table contains values for a0310a which are not allowed, specifically ^. The isc_val table contains values for a0310b which are not allowed, specifically ^. The isc_val table contains values for a0310c which are not allowed, specifically ^. The isc_val table contains values for a0310f which are not allowed, specifically ^.	fields A0200, A0310A, A0310B, A0310C, A0310D, and A0310F. Edit -3607 defines the allowed combinations which will produce a valid ISC. The invalid ISC's are noted in the table by a '—'. This table is for the convenience of developers if they wish to use it. Per the MDS 3.0 Data Specifications Overview document posted on the CMS MDS 3.0 Technical page: "There are 3,360 combinations of the possible values of these six RFA items. Most of these (2,542) are combinations of values that are not allowed (i.e., that will lead to record rejection). The remaining combinations can be mapped onto the ISC codes described above. Unfortunately, the logic for determining the ISC is not straightforward and cannot be reduced to a set of simple rules. To assist programmers, we have provided two options for determining the ISC code from the RFA items. The first option is to use a lookup table that is supplied with the data specifications. In the Access database, this table is called isc_val. The contents of this table are supplied with the data specs in a comma separated value file called isc_val.csv. This table contains one record for each of the 3,360 combinations of the ISC items. It also includes one additional record that corresponds to an inactivation ISC ("XX"). Each record contains a unique combination of the RFA items in the fields named "_val" (i.e., in A0200_val, A0310A_val, etc.). The ISC that is associated with the RFA combination is in the field called isc_id. If this field contains dashes ("--"), the combination of RFA values is not allowed. "Instead of using the lookup table, the programmer can implement the logic that is shown in Appendix B. This appendix contains the source code for a Visual Basic function that accepts the values of the six RFA items as string input, and returns the ISC value as a string. If the RFA combination is invalid, the function will return dashes ("--")."
20100225-022	E - Specs	This is for Section V, question V0200: In sub-question A there are 20 numbered lines. Each has a pair of checkboxes and a textbox in which data is to be entered. Appendix F of the RAI Manual (the matrix of full fields) only accounts for the two checkboxes on each line, not the data in the textbox. Likewise, in the submission specs, "Detailed specs Section	The text field in each question in items V0200A01 – V0200A20 is not submitted to CMS.

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		V", there is no specification for how that data would be submitted.	
20100225-015	E - Specs	Edit -3789 states: RULES FOR NEW RECORDS (WHERE X0100=[1]): a) If A0310A is equal to [01,03,04,05] (this is a comprehensive assessment), then submission date -V0200C2 (care plan completion date) should be less than or equal to 14 days. b) If A0310A is equal to [02,06] (this is a quarterly assessment), then submission date -Z0500B (assessment completion date) should be less than or equal to 14 days. c) If A0310A is equal to [99] and A0310B is equal to [01,02,03,04,05,06,07] (this is a PPS assessment), then submission date -Z0500B (assessment completion date) should be less than or equal to 14 days. d) If A0310F is equal to [10, 11] (this is a discharge assessment), then submission date -Z0500B (assessment completion date) should be less than or equal to 14 days. e) If A0310F is equal to [01] (this an entry record), then submission date -A1600 (entry date) should be less than or equal to 14 days. f) If A0310F is equal to [12] (this is a death in facility, record), then ssion date -A2000 (discharge date) should be less than or equal to s. Since I can have an NC record where A0310A = 1 and A0310F = 10 (for example), which rule applies, (a) or (d)?	In your example (where a discharge is combined with a comprehensive assessment), both rules would apply. Each of these rules is applied independently.
20100114-062	E - Specs	Will there be documentation on what has changed in the new version of the specs?	Yes. When you download the new version of the specifications, you will see there are two new reports: a Item Change Report and a Edit Change Report. These reports will give you a description of the changes.
20100114-051	E - Specs	Edit -3752 also does not reference all the required items it needs to complete this check. Only the items which contain the CAA trigger calculations are provided in the rltn_itm_txt and rltn_itms tables. These tables should also relate the items which are used to perform the CAA calculations.	Edit -3752 states that the CAA values should be consistent with the items used to compute the CAAs, but it does not list the component items. Similarly, edit -3616 states that the RUGs values should be consistent with the items used to compute RUGs, but does not list the component items. Because of the large number of items involved, we did not feel that these lists would be particularly helpful in the data submission specifications. The items involved in these calculations have been listed in the CAT and RUGs specifications.
20100114-049	E - Specs	Can you address the connection of the A0310 fields to the Item Matrix? How do they correspond with the types of	The overview document that accompanies the data submission specifications explains this connection (refer to

ID	Topic	Question	Answer
		assessments on the Data Submission Specifications? (examples NC, NQ, NP, NS, NSD, NO, NOD, ND, NT, SP, SS, SSD, SO, SOD, SD, ST)	the "Item Subset Codes" section). Briefly, we provide two ways of determining the ISC from the RFA items. First, you can use the lookup table in the isc_val table in the data dictionary or the corresponding CSV file. Second, you can use the logic provided in Appendix B of the overview document.
20100114-043	E - Specs	What will the new requirements be for calculating Length of Stay (LOS) within the MDS 3.0? When can we expect this information to be finalized?	The only place that an MDS 3.0 length of stay (LOS) measure is used in the QIES ASAP System is in the RUG-IV grouper. In order for the Special Medicare Short Stay RUG-IV rehabilitation classification to be used on an assessment, the end of the Medicare stay must be no later than the 8th day of the stay. This means that the Medicare End of Stay Date (A2400C) minus the most recent entry date (A1600) must be less than or equal to 7.
20100114-031	E - Specs	The data specifications for MDS 3.0 indicate that the file format (flat ASCII with .cms extension) will remain unchanged. Is this correct and will other file formats (e.g. XML) be supported?	The submission file must be XML. The flat file format will be ASCII for calling the grouper DLLs and will be the file produced by CMS.
20100114-023	E - Specs	Is an ARD (A2300) required on all assessments, including the discharge and reentry?	Item A2300 (assessment reference date) is an active item and is required on all MDS 3.0 records *except* the following: entry records (A0310F=01), death in facility records (A0310F=12), and inactivation records (A0050=3).
20100114-013	E - Specs	Z0300A and Z0300B Insurance Rugs are on the forms but not in the data specs (not submitted assumed). Z0400 (items a-l) are on the form but not the specs (not submitted assumed). Z0500A is on the form but not in the specs (not submitted assumed). In the data specs after the item Z0500B there is a list of items associated with the state or CMS side of the submission. We assume that a vendor has no need for this info unless in conjunction with state or federal submission outside of the normal process.	Z0300A and Z0300B (insurance RUGs and version) are not included in federal submissions to the ASAP system. These items are included on the printed item sets for the convenience of providers that need to submit MDSs to insurance companies.) In the data submission specifications, Z0500B is the last item that is included in federal submissions to the ASAP system. Filler and calculated items follow this item. The filler and calculated items are not included in federal submissions. When building a fixed-format string, these items should normally be blank-filled (except for the data end, carriage return, and line feed items). The calculated items will be populated in files received from CMS.
20100114-002	E - Specs	Could you review the documentation needed for Section M. If the wound occurred out of the facility, we may not have the initial start date etc. or do we use the date admitted to the facility? And if we do won't that trigger as being in house rather that out of house? Is there a utd choice to choose from? Thanks	Both the RAI manual and the data specifications allow for a dash-filled response which would indicate that the date of the oldest Stage 2 pressure ulcer is unknown. Please refer to the Coding Instructions for M0300B in Chapter 3, Section M, page M-9 for details on how to code this item..

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20121210-011	F-State Options	I am contacting you in regard to a validation error message. The validation report says: Z0200A, RECALCULATED_Z0200A, Z0250A, RECALCULATED_Z0250A RAC, SSB, AAA, RAD -3616a WARNING Incorrect HIPPS/RUG Value: The submitted value of the HIPPS/RUG code does not match the value calculated by the QIES ASAP System. The assessment in question had a RUG III score of RAC on the assessment for Z0200A. Georgia is a case mix state and Z0200A is used in our CMI calculations. The SSB has a CMI of 1.736 while the RAC is a CMI of 1.936. This resident had ST/OT/PT with minutes 125 & 4 days, 200 & 4 days, and 175 & 5 days. The ADL score under RUG III is 15. According to the crosswalk for RUG III this assessment should be an RAC. I downloaded the assessment through Casper to check the assessment. It has all the information listed herein but with a Z0200A of SSB.	SSB is correct for the GA RUG III index maximized calculation. GA uses CMI set D01 for their calculation. In the D01 CMI set RAC has a value of 1.31 and SSB has a value of 1.33 so SSB has a higher index (value) than RAC and so SSB is returned as the index maximized RUG in the ASAP recalculated Z0200A value. Since the indexed values you provided do not match the D01 CMI set index values, it appears your software is not using the D01 CMI set..
20121210-012	F-State Options	I have questions about what the states can setup so that the Z0200 and Z0250 RUG scores are validated by the *ASAP MDS Validation System*. It would be helpful to know this information so that we can mirror the available RUG setups in our products.	The discussion below describes what the ASAP system will do. If the state wants to do any other type of Medicaid calculation, the state must do that in their Medicaid system. It will not be done by the ASAP system. If the state wants the ASAP system to recalculate the Medicaid RUG values on an MDS 3.0 NP, NQ, or NC assessment, the state can set up the parameters in the MDS 3.0 DMS. This set up of parameters in the MDS 3.0 DMS will cause the ASAP system to recalculate the Medicaid RUG submitted based on the parameters entered by the state into the MDS 3.0 DMS. The parameters that the state can set in the ASAP system are listed in the consolidated Q & A's on the MDS Vendor page in question 20101101-025 The ASAP system only allows the state to choose the following parameters when having the ASAP system

ID	Topic	Question	Answer
			recalculate Medicaid RUGs 1 - Choose RUG IV version 1.00 model 66, 57 or 48 or RUG III version 5.20 model 53, 44, or 34. 2 - Choose a CMS defined CMI code set(s) or create a specific state defined CMI code set(s) for urban and for rural for the calculation. 3 - Choose the beginning and ending effective dates for which the Medicaid RUGS will be calculated. The target date of the assessment will be compared to the beginning and ending effective dates for the RUG calculation. If the target date is equal to or greater than the beginning date and equal to or less than the ending date, the RUG will be calculated. The state cannot choose the rehab parameter in the MDS 3.0 DMS. The ASAP system always uses "OTHER" for the rehab parameter in recalculating the Medicaid RUGs.
20121210-013	F - State Options	We are software vendors in the state of Illinois. We have a question regarding items collected for NQ ISC for the state of Illinois. As per the Additional items required document published by the CMS, it is required to include all V section elements in the NQ assessment. When one of our clients checked with the state coordinator, then have indicated that there is no need to submit V sections in NQ. Following are my questions: 1. Is there any other document besides the one published by the CMS? 2. Is it mandatory to submit the V sections in the NQ for the state of Illinois? 3. If the MDS is submitted without V section will it be rejected? Moreover, in the jRaven software V section is not included for the state of Illinois.	The Additional Items Required by States that is a link published on the Vendor Section of the QTSO website: https://www.qtso.com/vendormds.html is correct. Illinois collects all CMS defined items EXCEPT for G0900A, G0900B, and (also except for) all Section V items. All Section V items are within this exception list so are not collected. In the future, for state specific issues/questions, please contact the state directly.

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		Please clarify whether to include the V section or not in the NQ assessment for the state of Illinois. https://www.qtso.com/download/mds/Additional_Items_Required_by_States_for_Nursing_Home_MDS_05092012.pdf	
20110126-016	F-State Options	In New York, they are adding two Section S fields and eliminating others effective April 1; can all fields be submitted for a short period of time after April 1?	Section S fields that are not active but submitted anyway, (as long as they are formatted correctly), are ignored. They are not stored, edited, nor receive warnings.
20101220-013	F-State Options	It would be extremely helpful if CMS would publish which RUG each state selected for Z0200 and Z0250. States are not reporting that information accurately to us. In fact, one state told us version 09 and there is no 09.	There is a RUG version 09. It is RUG III, 53 group, version 09. The grouper version code that the grouper returns (found in the RUG III grouper specs posted on the CMS website) will be 07, 08, or 09, depending upon the number of groups.
20101101-016	F - State Options	Can CMS confirm that Connecticut has authorization to use the NC MDS 3.0 form in place of the NQ and NP? I cannot find documentation to that fact, but am getting push back from our clients in CT.	Connecticut is not collecting additional item on the NQ nor NP assessment. They had been approved to collect the item and then decided not to collect them.
20100820-030	F - State options	Since the file is being sent to CMS first and then CMS is providing the data to the states under MDS 3.0, our question is whether vendors have to filter for state excluded values such as STDs and HIV or will CMS filter those values before providing data to the states from the national system?	It is the state regulation/law/statute that requires NO submission of identified HIV and/or STD diagnosis; therefore, providers should take the appropriate editing to prevent this from happening. The QIES system will edit out a specific ICD-9 code that the state determines inappropriate and designates as such in the CMS QIES system. This does not supersede the provider from submitting the banned codes i.e. the state may inadvertently miss adding such banned codes in the CMS QIES system. The onus is on the provider to ensure they are compliant with state specific requirements.
20100820-029	F - State options	Some other states are currently sending back case mix index reports to the MDS server and storing the reports in the individual facility folders for the facilities to access. Will this option be available once the facilities' validation reports are moved into the CASPER system?	At this time, some states distribute reports to their facilities by putting them into the facility directory on the CMS owned state server. At this time States have been told that they can continue to use these folders to distribute the state created reports to their facilities. This can occur so long as the MDS 2.0 system is available for submission. CMS has not made a decision on what will happen after MDS 2.0 is discontinued. The subdirectory name is strpts.
20100820-009	F - State options	A State uses a Comprehensive without section V for their Quarterly MDS Assessment. How will the ASAP computer system edits know what should be on this state's Quarterly? What if someone uses jRaven? Will CMS create a form for	States can request CMS to add items to the OBRA quarterly (NQ) and/or PPS (NP) assessment for their state. The items available for addition to these ISCs are identified by an 's' (lower case letter s) under the ISC column in the

ID	Topic	Question	Answer
		the specific state Quarterly Assessment? If so, how can I get a copy?	MDS 3.0 Data Specification's file itm_sbst.csv or by having the NQ and NP item subset codes listed in the State optional: NQ,NP line for the item in the MDS 3.0 Data Specifications Detailed data specs report. After approval by CMS, CMS will update the ASAP system to add the requested items to the requested NQ or NP assessments for that state as active items. As active items, they will be edited and stored by the ASAP system. If any of these active items are missing or fail a fatal edit, the record will be rejected. For example, a state has requested and been approved to have all the available items that are not in Section V added to their OBRA quarterly (NQ) records effective October 1, 2010. All NQ records submitted in this state with a target date on or after October 1, 2010 will have these requested items active. This is a change to the items on the state's OBRA quarterly (NQ) record. It is not a different type of comprehensive (NC). If providers send in an NC that is missing the Section V items, it will be rejected. Section V items are active on NC records. JRAVEN has functionality to accommodate the specific state's quarterly additional items. CMS does not create state specific printable item subsets.
20100820-005	F - State options	Could you please advise vendors of the options for question A1300A-D? Per the MDS 3.0 data specs v1.00.3: * A1300A-D items are active on all ISCs except XX * A1300A-D items are not state-optional on any ISC * Each may be completed with a text value or can be left blank We vendors are hearing from more than one state that they "require" or that providers must "complete" the A1300A-D items on all assessment types (ISCs) and that vendors should comply with the state requirement. They also are indicating that these questions are state-optional.	The ASAP system will edit items per the MDS 3.0 Data Specifications. The States can implement additional requirements for Medicaid purposes; however, the ASAP system will edit based on MDS 3.0 Data Specifications.

ID	Topic	Question	Answer
		Can you please explain how the states can make these items required or that providers must complete the items if the CMS data specs say they may be left blank?	
20100720-048	F - State options	How will the state Medicaid agency know that a MDS 3.0 record that was received in a previous text file has been inactivated or modified and should have an end date? My concern is that some of our case mix states enforce a transmission cut-off date for the case mix rate setting reports. In this case the modification and inactivation date for an assessment is necessary for the reports. The MDS 2.0 data has an ast_beg_ver_dt and an ast_end_ver_dt. We receive the entire asmt_hist table with each MDS 2.0 data export and all of the records in this table have a valid end date. Once we have this data imported we remove all of the existing records in our existing version of the assessment table that have been inactivated or modified and are now in the asmt_hist table.	Accepted modifications and inactivation requests will be sent in the state assessment extract flat file. The Medicaid agency can tell whether it is a correction or an inactivation by querying the A0050 Type of Record Item. A record is effective (equivalent to the MDS 2.0 ast_beg_ver_dt) on the submission date. The record is no longer effective (equivalent to the MDS 2.0 ast_end_ver_dt) on the submission date of the subsequent accepted correction or inactivation request. The assessment end version date is not stored on the record. The subsequent version of the record or the inactivation request must be queried to determine the end date of the prior one.
20100720-040	F - State options	I have a couple of questions on how corrections will be handled in the daily file that will be “pushed down” to CMS QIES servers at each state: Each record has a MDS _ASMT_ID and an ORGNL_ASMT_ID. 1) When A0050 = 1, Add new record, are the values for both the MDS_ASMT_ID and ORGNL_ASMT_ID the same? 2)When A0050 = 2, Modify existing record, is the ORGNL_ASMT_ID always equal to the value assigned when the assessment was first added, regardless of how many modifications are submitted? 3) If a nursing home adds an assessment record and on the same day submits two modifications of this record, what order will these records be listed in the daily file? What will be the sort order of records in the daily file?	1) When A0050 = 1 the values for both the MDS_ASMT_ID and ORGNL_ASMT_ID will be the same value. 2) When A0050 = 2, Modify existing record, the ORGNL_ASMT_ID will always equal the original value assigned when the assessment was first added, regardless of how many modifications were submitted. 3) There is no sort order on the state extract file. Note: If the state wants to process them in a certain order then they can sort them prior to processing. With MDS 3.0, submitters were not required to put a zero in X0800 Correction Number for original records. If it is an original record X0800 is part of a skip pattern so is a caret. The values of X0800 are caret (^) for an original record and 1 through 99 for a modification or inactivation record.
20100720-014	F - State options	Z0250 - Alternate State Medicaid Billing (RUG and RUG version) Do the states have a way to set up this field so that the "^ (Blank, not available or unknown)" is not a valid option?	Z0250 - If a state sets up parameters for the ASAP system to perform Medicaid RUGS calculation 2 (Z0250A), then the ASAP system will recalculate the Z0250A value and issue warning edit -3616 if they do not match. This includes issuing the edit if a blank is submitted and the state sets up Z0250A to be calculated by the ASAP system.

ID	Topic	Question	Answer
20100720-011	F - State options	Z0250 is active on the NC, NQ, and NP subsets but is inactive on the remaining subsets. Do the states have a way to make the remaining subsets (except XX, I guess) active? Do the states have a way to set up this field so that the "^ (Blank, not available or unknown)" is not a value option so that a value is required? Warning Edit -3616 says: "If the item is active and contains a value, the value should be consistent with all of the MDS items used in the RUGs classification (i.e., the RUGs calculation should be correct)." This suggests that even for the NC, NQ, and NP, if it doesn't contain a value, there won't even be a warning.	No, states can only add items to the NQ and NP ISCs. They cannot add non-section S items to any other ISC. If a state sets up parameters for the ASAP system to perform Medicaid RUGS calculation 2 (Z0250A), then the ASAP system will recalculate the Z0250A value and issue warning edit -3616 if they do not match. This includes issuing the edit if a blank is submitted and the state sets up Z0250A to be calculated by the ASAP system.
20100720-010	F - State options	A1300A is active on all subsets but the XX and it has item values of Text or ^ (Blank, not available or unknown). Do the states have a way to set up this field so that the "^ (Blank, not available or unknown)" is not a value option?	The ASAP system will edit items per the MDS 3.0 Data Specifications. The States can implement additional requirements for Medicaid purposes; however, the ASAP system will edit based on MDS 3.0 Data Specifications.
20100926-018	F – State options	We vendors are hearing from more than one state that they "require" or that providers must "complete" the A1300A-D items on all assessment types (ISCs) and that vendors should comply with the state requirement.	The ASAP system will edit items per the MDS 3.0 Data Specifications. The States can implement additional requirements for Medicaid purposes; however, the ASAP system will edit based on MDS 3.0 Data Specifications.
20100926-017	F – State options	Is it possible to get a copy of your state-optional info as we did the Section S info?	The document, Additional Items Required by States for Nursing Home MDS 3.0 Assessments is posted on the vendor link of the QIES Technical Support Office website: https://www.qtso.com/vendormds.html. This document lists the States that have been approved for additional CMS defined items on their Quarterly (NQ) or PPS (NP) assessments.
20100926-016	F – State options	Will there be an alternate Item Subset posted for a full Quarterly (ISC = NQ) without Section V? So far 2 states have elected to utilize all state optional items, except Section V. If not, which subset are we to use for the printed MDS 3.0 NQ when the state requires a full quarterly?	CMS does not create state specific printable item subsets.
20100926-015	F – State options	Since the footer of each the Item Subset MDS3.0_Comp is 'MDS 3.0 Nursing Home Comprehensive (NC), it does not appear that we can use that set for a Quarterly as the form	For October 1, 2010, the states asking for additional items on their quarterly do not want the Section V items. This is a change to the items on the state's OBRA quarterly (NQ)

ID	Topic	Question	Answer
		name would be confusing.	and/or PPS (NP) record(s). It is not a different type of comprehensive (NC). If providers send in an NC that is missing the Section V items, it will be rejected. Section V items are active on NC records.
20100820-016	G - Section S	How will the ASAP system edit Section S items with an Item Type of TEXT?	The ASAP system edit for Section S items with an Item Type of TEXT (S0140, S0141, S0150, S6100F1, S6100F2, S6100F3, S8050B, S8050C, S9020, S9080C) accepts all printable characters as valid values. The submitted values are trimmed of all leading and trailing blanks (ASCII hex '20'). If all characters in the submitted value are blanks (ASCII hex '20'), they will be trimmed off and the value of the item would be considered missing. A missing value will receive the -3808 warning message. To designate that the item has been addressed and is blank, a caret (^) should be sent as the value for the Section S TEXT item values. A caret is accepted by the ASAP system as a valid character and no warning message is issued. Note: The ASAP system will edit items per the MDS 3.0 Data Specifications. The States can implement additional requirements for Medicaid purposes; however, the ASAP system will edit based on MDS 3.0 Data Specifications.
20100820-015	G - Section S	If a state asks for items where the instructions or intent requires a skip what is expected in the data. For instance S6050 is asking if Isolation Precautions are needed and if you answer Yes then you answer S6051A, B, C, D checkboxes. The specs allow for a 0, 1 in the checkboxes. But if they are skipped should they be blank or contain a caret? How will the VUT handle cases where the value is out of the range of the specs in a case like this?	The response options that are listed in the data specs for the Section S items were provided to CMS by the States. A skip (caret) is not listed as a valid response for the S6051A-D items and should therefore not be submitted. If a caret was submitted for these items, it would trigger Edit - 3808, resulting in a warning. Furthermore, enforcement of a skip pattern like the one mentioned is outside the scope of ASAP because the system does not enforce relational edits for Section S. This is something that the State might choose to enforce in its Medicaid processing system. We therefore recommend that the vendor contact the State responsible for the items in question to find out how they should be handled in the situation he describes.
20100820-007	G - Section S	The State of New York, in direct contradiction of published CMS requirements for Section S, has changed the wording on question S0520 and is mandating that facilities and vendors use NY state specific wording on software and forms. (The NY documentation states: *The MDS 2.0 Question S5 has been temporarily assigned to MDS 3.0 Item S0520. This assignment will change on April 1, 2011. The	We understand your concern that software vendors are under pressure to provide products for the MDS 3.0 release. CMS is advising states that they have to timely notify their vendors on not only Section S items but any and all of the configurable items in an assessment (e.g. RUG specifications, prohibited HIV/STD codes and additional items on their quarterly or PPS assessments).

ID	Topic	Question	Answer
		wording for the NYS Questions/Responses for S0520 does not match the wording posted by CMS for S0520. This discrepancy is required to fix a MDS transition problem. All systems and documentation for NYS providers MUST use the NYS wording. The April 1, 2011 correction for this discrepancy WILL require minor changes to software systems intended for use by NYS providers.) Their form also seems to have slightly different verbiage for S8010A3 and S8010I3 responses, slightly different verbiage for the question text on S9060, and include inter-item edits between the S80xx items that are not included in the CMS data specs. While this seems like a nominal issue, it is a substantial hurdle for compliance for both vendors and facilities. It means that software must be modified at the eleventh hour to accommodate an alternate set of question wording (but this could conceivably extend to questions, responses, numbering, error checking and skip patterns if allowed by CMS) on the MDS. This is something that was never anticipated and never designed into software applications. We would prefer for the State of New York to adhere to the originally published requirements. Can CMS assist with standardizing Section S with the state of New York?	CMS has approved New York's request to use item S0520 as a "stand-in" item for their state required Medicaid item from October 1, 2010, through March 31, 2011. As stated in the New York documentation, MDS 2.0 Question S5 has been temporarily assigned to MDS 3.0 Item S0520. New York's needed items will be added by CMS in the April 2011 release. The valid values for S0520 are the same valid values (with different descriptions) as the MDS 2.0 Question S5. The use of this "stand-in" item will allow submitted values to pass the ASAP system edits, be stored by the ASAP system and be passed on to the state of New York for use in their Medicaid system.
20100720-005	G - Section S	I understand that CMS regards Section S as a “state” matter and that they have no responsibility to share Section S information with anyone because that is a state requirement. The problem is that evidently some states feel they have no responsibility to share this information or are unable to share it at this time.	As announced on the April 20, 2010, Vendor call, CMS is advising states that they have to notify their vendors on not only Section S items but any and all of the configurable items in an assessment (e.g. RUG specifications, prohibited HIV/STD codes and additional items on their quarterly or PPS assessments). We will again remind States that they need to communicate with vendors about Section S. Note: CMS has published two documents on the QTSO website at: https://www.qtso.com/vendormds.html . One document contains which items each state has been approved by CMS to collect. Another document contains the states which were approved by CMS to collect additional items on their quarterly (NQ) and/or PPS (NP) assessments.
20100420-Ad Hoc21	G - Section S	Will vendors be required to contact States to find out what the Section S format should look like?	Yes, contact state agencies. We did include item text for Section S items in the new version (1.00.2) of the data specs.

ID	Topic	Question	Answer
			CMS has been reminding state agencies they need communicate with vendors about Section S.
20100926-019	G – Section S	How will CMS transmit Section S data to the various states? We are hearing terms like the "translator". Is this an individual state program which would receive the Section S data then create a RUGs III/ reimbursement rate for Medicaid residents? How exactly does this work?	CMS will supply the accepted MDS 3.0 records to the appropriate state in a standard process. This includes all data in the record including Section S.
20121210-014	H - VUT	Can you help me understand why the VUT is telling me that -3676 (invalid value A0050) is failing when the following is true • SPEC_VRSN_CD = 1.02 • X0100 = 1 • A0050 is NOT PRESENT If the VUT is applying 1.02 rules for the submission specifications, I cannot see how error -3676 would apply since it was not added until 1.10. Does the VUT only support a single version of the submission specifications (1.10) or does it look at SPEC_VRSN_CD to determine which version to apply?	The VUT determines what items should be present in the assessment based on the target date, not the SPEC_VRSN_CD.
20110126-018	H-VUT	We are using the VUT in an unattended fashion. When an exception happens that is not a normal exception, (not a fatal warning), it pops up a message box and halts processing. Could that be changed to write the message to a log file so it doesn't halt processing?	This enhancement was implemented in the 09/06/2011 release of the VUT (Version 1.2.0).
20100926-022	H - VUT	I have attached a number of files that we are having issues with. When we run then through the VUT, we see notification pop-ups with no text a number of times, but the files still process. Any feedback is greatly appreciated.	The XML files you submitted contained some invalid or extraneous tags. It appears you used itm_db_id from the specs master table for the tag instead of itm_id. The current version of the VUT displays a pop-up message box. We are updating the VUT so it will ignore any extra tags similar to the ASAP system.
20100926-021	H - VUT	I also want to know if there is any variance that would justify testing in multiple states?	The VUT could be utilized for testing Section S and state optional items.
20100926-020	H - VUT	Is the VUT tool the exact same software used on the CMS	No, the VUT enforces the edits as part of jRAVEN and can

ID	Topic	Question	Answer
		server to validate assessments?	be used to validate MDS 3.0 submission files in XML format, but it is not used as part of the ASAP system.
20100820-041	H - VUT	Could you provide the edits you used for your utility tool in a document? I want to compare them to our edits to be sure that they are complete and accurate.	If you haven't done so, try looking through the MDS 3.0 Technical Information page. It has information on the MDS edits as well as data specs. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html. The VUT uses the specs MDB for just about everything, except it also has an ICD9 lookup, the CAA rules, and it has configuration files to know what Section S and extra quarterly items are active for each state.
20100720-022	H - VUT	Do you have the actual code that performs the VScan? We would like to start with whatever code/pseudo code there is.	CMS will not be providing source code for the VUT. Historically, we did not provide source code for the MDS 2.0 validation DLLs of the past, either.
20100720-021	H - VUT	Is there a DLL for XML files?	There is not a validation DLL. The VUT is an EXE file that uses XML files for input and output.
20100926-024	I - jRAVEN	Is there a free MDS 3.0 download from CMS similar to the Raven Software with the 2.0. I have been told "Yes" that there would be. I have been on the CMS site for the past two weeks and am unable to locate. Is this download available to the healthcare community as of yet? If so, where can I locate this information on the CMS site?	There is only one CMS MDS 3.0 assessment tool. It is jRAVEN which is used for both swing beds and nursing homes. It can be downloaded from https://www.qtso.com/ravendownload.html#jRAVEN.
20100926-023	I - jRAVEN	I manage a swing bed wing at a hospital. I have been unable to locate any software to complete the MDS 3.0 which is effective October 1, 2010. Can you please tell me if CMS will be offering a free download as they did in the RAVEN software for the MDS 2.0? I am unable to locate any information about this on the CMA website.	jRAVEN software supports MDS 3.0 for both nursing homes and Swing bed facilities is available free of charge. It was posted September 15, 2010 on the MDS 3.0 Technical Information link found on the CMS Website: http://www.cms.gov/NursingHomeQualityInits/01_Overview.asp#TopOfPage. The jRAVEN download can also be found on the QTSO website: www.QTSO.com.
20100820-049	I - jRAVEN	Will swing bed providers still be able to use the RAVEN software? If not, does CMS have a vendor similar to RAVEN? Trying to determine transition.	Yes – a single install of jRAVEN supports both nursing homes and Swing bed facilities.
20100820-046	I - jRAVEN	What are the system requirements for jRAVEN?	jRAVEN requirements are located on the QTSO website: www.QTSO.com.
20100720-017	I - jRAVEN	When will RAVEN for MDS 3.0 be available?	It was posted September 15, 2010 on the MDS 3.0 Technical Information link found on the CMS Website:

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			http://www.cms.gov/NursingHomeQualityInits/01_Overview.asp#TopOfPage. The jRAVEN download can also be found on the QTSO website: www.QTSO.com.
20100114-033	I - jRAVEN	Will the new version of RAVEN support other file formats?	The application will provide the user the ability to export zipped XML files and the capability to export files as standard fixed text files.
20100926-026	J - Test	Will vendors and/or providers be able to submit XML files to the CMS QIES ASAP system on October 1 that have the test flag indicator set to yes or will the system only accept files that the flag set to indicated a production file?	The ASAP system should not be used as a test system for submissions. Facilities and vendors should use the VUT to validate records to be submitted.
20100926-025	J - Test	We are a software vendor that would like to begin file submission testing with the MDS 3.0. Can you please advise us on how to do this?	There is not a test system available to send test assessments through to the new MDS 3.0 system. There is, however, a Validation Utility Tool (VUT) that can be used to validate MDS 3.0 submission files in XML format. The tool enforces the edits that are mapped to the MDS 3.0 items, as published in the MDS 3.0 specifications
20121210-015	K-RUGs	Our QA department found new RUGs in the latest DLL that was sent out: RAE, RAD, RAC, RAB, RAA. And there 72 RUGS, not 66. At first they thought it was a fluke-this is the urban special Medicare in the example, but it appears in other groupers in the RUGS IV groupers. I don't recall hearing about new RUGS. Did I miss something? We are trying to get our programming ready for Oct. and this is a problem.	The CMI sets contain RUG values for ALL models of the RUG. For RUG IV, this includes the 66, 57 and 48 models of the grouper. All CMI sets for the RUG IV grouper contain 72 entries. As a note, all grouper CMI sets for the RUG III grouper (53, 44, and 34 models) contain 58 entries. The CMI values not used for that model have a CMI value of zero (0.00). The CMI value for RAE, RAD, RAC, RAB, RAA in the CMI sets E01, E02, E03 and E04, are zero because these RUG groups are not returned for the 66 group model and CMI sets E01, E02, E03 and E04 are CMI sets for the 66 group model. For code set F01, only RAE, RAD, RAC, RAB and RAA have CMI values. All of the other rehab groups are zero. This is because the F01 set is for the 48 group model which only uses the rehab groups RAE, RAD, RAC, RAB, RAA. Similarly, looking at the F02 code set used with the 57 group model, the only RU* rehab groups used are RUA, RUB, and RUC and these have CMI values greater than zero. The RUX and RUL rehab groups are not used in the 57 group model have values of zero.
20121210-016	K-RUGs	Does the RUGS DLL version code v1.02.1 replace the RUGS	The Medicare RUG IV logic version continues to be 1.02

ID	Topic	Question	Answer
		version code 1.0266 for Z100B and Z150B effective as of 7/18/2012?	with the implementation of the new 1.02.1 code version of the DLL. The Medicare RUG-IV version code (Z0100B and Z0150B) of 1.0266 is not changed with the new DLL. The DLL code version of 1.02.1 continues to use logic version 1.02 and corrects a rare problem that occurred with code version 1.02.0.
20121210-017	K-RUGs	I have an assessment that was accepted, but with a warning. (-3616a) The QIES ASAP system recalculated a submitted score of RHC04 (which is correct by the hierarchical method) with a score of HD2- which is correct as the non-therapy RUG. Why would CMS replace a rehab score with a lower ranking one?	For future issues, you should contact your State Automation coordinator. CMS uses the indexed maximized method not the hierarchical method of RUG calculation. Since CMS uses index maximizing, you should reference the payment rates for each of the RUG categories for the appropriate CMI set. There are several times when the non-Rehab RUG has a higher CMI value. When this is the case, Z0100A will return a non-therapy RUG. If the facility associated with this MDS is classified as urban, then HD2 does have a higher CMI than RHC. If the facility is rural, then RHC has the higher CMI. Please verify that your software is set properly, urban vs rural for the proper CMI and it is using index maximization not hierarchical method.
20121210-018	K-RUGs	Some of our clients are starting to get validation report Warnings for EOT-R assessments and MDS 3.0 item Z0100. In one case we calculated a RHA0A, and it was recalculated to HB10A. In another case we calculated RUC0A, and it was recalculated to RMB0A. The example assessment is in the RAI manual 2-49 #3 (10/2011). Would either of you be able to help me with this problem? We are pulling the previous RUG- IV therapy classification level into Z0100. Does the QIES ASAP System look at the previous RUG-IV therapy classification level when showing this warning?	For the assessment provided , the manually calculated RUG (RMB) is the same as the ASAP system or recalculated Z0100 RUG value. Since the submitted Z0100 value of RVB01 did not match the system recalculated RUG, the ASAP system correctly returned the warning error message on the Final Validation Report. The details for this assessment are: ADL calculation: G0110A = 4 G0110B = 2 G01110I = 2 G0110H = 0 Total ADL = 8 for RUG calculation Rehabilitation calculation:

ID	Topic	Question	Answer
			O0400A - are all zero minutes O0400B1 = 273 O0400B2 = 0 O0400B3 = 0 O0400B4 = 4 O0400C1 = 277 O0400C2 = 0 O0400C3 = 0 O0400C4 = 4 Total Therapy minutes = 550 Total occupational therapy days = 4 Total physical therapy days = 4 To be an RV_ (very high) RUG group, for a non-short stay assessment, 2 criteria must be met (see page 6-34 and 6-35 of the MDS RAI manual). Total Therapy minutes of 500 minutes or more and At least 1 discipline (O0400A4, O0400B4, O0400C4) for at least 5 days. This record in question had over 500 minutes of therapy, but did not have any discipline for at least 5 days. Both disciplines were for 4 days. The RH_ (high) RUG group for a non-short stay assessment has the same number of days criterion so this assessment did not qualify for the high rehab group. (see page 6-35 of the MDS RAI Manual) The RM_ (medium) RUG group criteria is Total Therapy minutes of 150 or more and At least 5 days of any combination of the three disciplines (O0400A4, plus O0400B4 plus O0400C4).

ID	Topic	Question	Answer
			This record had 0 + 4 +4 = 8 days so it qualifies for the RM_ group. Perhaps it is that the other RUG issues are similar in that they do Not have the required five days in one discipline. Please note: The VUT (Validation Utility Tool) does not Recalculate RUG values, which is why no error was returned when the record was run through the tool. The following message displays with the Validation Utility Tool posting on the QTSO website: "The VUT does not currently interface with the RUG III and IV DLLs – therefore, it does not recalculate nor confirm that RUG values are correct."
20121210-019	K - RUGs	There seems to be an issue with the RUG-IV grouper program where it won't recognize an assessment as a RMA RUG-IV Class, instead its returning an error. The assessment in question is an NP PPS 5 day start of therapy short stay assessment. To test this I only used the Speech Therapy - Individual Minutes, set the number of days as 1, set the therapy start date at 5/14/2012 and therapy end date as 5/14/2012, so there is only 1 day on which therapy was performed. I then changed the amount of therapy minutes to see which class it returned. Below are the values I used, a table of the minutes that I used and the values I got back. A2000. Discharge Date: 05/14/12 A2300. Assessment Reference Date: 05/14/12 A2400B. Start date of most recent Medicare stay: 05/10/12 A2400C. End date of most recent Medicare stay: 05/14/12 ADL Score: 4 O0400A4. Days: 1 O0400A5. Therapy Start Date: 05/14/12 O0400A6. Therapy End Date: 05/14/12 Individual Minutes RUG-IV Class Returned Is this a Medicare Short Stay Assessment?	The CMS Medicare RUG calculation uses Index Maximizing. Grouper Error 5 does indicate a Start of Therapy assessment that does not yield a rehab/extensive or rehab classification (group does not start with "R") for the Medicare HIPPS Code in Z0100. With 64 average rehab minutes, the Start of Therapy assessment will qualify for Medium Rehab. However a lower (non-rehab) Medicare classification can occur because of Medicare index maximizing. When a resident qualifies for multiple groups, index maximizing assigns the group with the highest CMI (the highest payment rate). With ADL 4, the RMA group will index maximize to any of the following groups: HB2, HB1, and LB2. If the resident has appropriate qualifiers for any of these groups, then classification will be that group (not RMA) and an Error 5 will be returned by the grouper.

<table>
<tr><th>ID</th><th>Topic</th><th>Question</th><th>Answer</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Individual Minutes</td><td>RUG-IV Class Returned</td><td>Is this a Medicare Short Stay Assessment?</td></tr>
<tr><td>144</td><td>RUA17</td><td>Yes</td></tr>
<tr><td>100</td><td>RVA17</td><td>Yes</td></tr>
<tr><td>65</td><td>RHA17</td><td>Yes</td></tr>
<tr><td>30</td><td>Error: 5</td><td></td></tr>
<tr><td>15</td><td>Error: 5</td><td></td></tr>
</table>

The error that is being returned is:

Z0150 A start of therapy OMRA does not result in a Rehabilitation plus Extensive or Rehabilitation group. Error 5

I have gone through the worksheet to calculate the RUG Group and I can't find the reason that it would return a class if the minutes are 65 or higher but will return an error if the minutes are 64 or less. The assessment meets all the requirements for the RUG-IV Group RMA17, so then why is it returning an error?</td><td></td></tr>
<tr><td>20111110-009</td><td>K-RUGs</td><td>When will the ASAP system begin using version 1.02 of the RUG IV grouper and version 1.00.4 of the RUG III MDS 30 Mapping specifications?</td><td>As both versions are backwards compatible, the ASAP system will use the new versions immediately following the September system downtime. They will be used for all RUG IV and RUG III calls regardless of the target date on the MDS 3.0 assessment.

After the September 2012 implementation, the ASAP system will use version 1.02 for all RUG IV calls (both CMS and state) sending the appropriate parameters based on the target date of the record and the CMS and state requirements. The version values for RUG IV version 1.02 are returned in the B items (Z0100B, Z0200B, Z0250B).
1.0266 - RUG IV 66 groups
1.0257 - RUG IV 57 groups
1.0248 - RUG IV 48 groups</td></tr>
<tr><td>20111110-010</td><td>K-RUGs</td><td>For the October 1, 2012 release, I am not finding anywhere in the documentation on the RUG information where it says</td><td>Here are locations of documentation concerning "index</td></tr>
</table>

ID	Topic	Question	Answer
		how to set the sRehabType when using the RUG dll's. Is the following a correct assumption for setting these values: * If the ARD Date is greater than or equal to 10/1/2011 and it is a Medicare assessment then sRehabType = MCAR2 * If the ARD Date is less than or equal to 9/30/2011 and it is a Medicare assessment then the sRehabType = MCARE * If not a Medicare assessment then the RehabType = OTHER	maximizing": 1. There is an "Index Maximizing" section in Chapter 6 of the RAI Users Manual. 2. There is discussion of index maximizing on page 8 of the "RUG-IV grouper overview" document in the RUG-IV package and on page 18 of that document. There is presentation of the standard CMI sets for index maximizing. When setting the DLL sRehabType parameter, the type of assessment does not matter. The setting for this parameter is contingent on the MDS 3.0 RUG item (e.g., Z0100A for normal Medicare RUG) and the assessment reference date (A2300). The rules are: 1. For Z0100A (Medicare RUGs: • sRehabType = 'MCARE' for all assessments (PPS and non-PPS assessments) with assessment reference date before 10/1/2011. • sRehabType = 'MCAR2' for all assessments with assessment reference date of 10/1/2011 or later. • Note that the DLL provides the value for Z0100A in sRugMax and the value for Z0150A (Medicare non-therapy RUG) in sRugMax_NT. 2. For Z0200A and Z0250A (Medicaid RUGs): • sRehabType = 'Other' for all assessments (PPS and non-PPS) for all assessment reference dates.
20111110-011	K-RUGs	I realize that a Short Stay MDS or an SOT MDS will be rejected from the system if the Z0100A data does not begin with an R (for a Rehab group). -3804 FATAL Error. I have an odd situation where a Short Stay MDS RUG score otherwise qualifies for a non-rehab group because of index maximization (CC1 vs. RLA). I believe that this could potentially be the same situation for an SOT assessment. Can you confirm for me that we should not be considering	To qualify as a Medicare Short Stay assessment, the assessment must be an SOT assessment. The difference between a Medicare Short Stay assessment and a non-Short Stay SOT assessment is that the Short Stay assessment uses the average daily minutes of therapy for rehab classification. The non-Short Stay SOT assessment uses the normal total minutes of therapy for rehab classification. In both cases (short stay or other SOT), the

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		index maximization in this situation for a Short Stay or an SOT MDS?	indexed maximized Medicare RUG (Z0100A) group must be a rehab group starting with an "R". Any SOT will be rejected unless the Z0100A value recalculated by the ASAP system using index maximizing is a group starting with "R".
20110803-006	K-RUGs	Assuming the FY2012 rule is approved and the v1.01.1 RUG IV code is implemented on October 1, I have a question regarding the correction for the short stay indicator and the potential for rejected assessments. Will the correction in the Medicare Short Stay Indicator calculation apply to all MDS Assessments regardless of Target Date? Per the code *Set Medicare Short Stay Indicator (l_Mcare_short_stay); /*V1.01.1 CHANGES: 1. A03100C must = '1' rather than '1' or '3'; 2. sRehabType can = "MCARE' or "MCAR2' rather than just "MCARE' There are 2 potential scenarios that are of concern 1. If the assessment where A0310C = [3] is completed prior to the October 2011 implementation, it could calculate the Short Stay Indicator = [1] utilizing the v1.00.9 code. This could result in a valid RUG calculation where the first letter is R due to the special Medicare short stay calculation. If the submission file is submitted on October 1, 2011, will the RUG group be recalculated using the v1.01.0 code and the assessment be rejected? 2. It appears that a Modification could be rejected, if the assessment is a Modification with the original assessment A0310C = [3] that was accepted prior to October 1. The Short Stay Indicator = [1] AND resulted in a RUG calculation with where the first letter is R due to the special Medicare short stay calculation. If the Modification is created on or after October 1, 2011, the v1.01.1 calculation will return the Short Stay Indicator = [0] AND the default AAA RUG calculation. Note: Version 1.02.0 of the MDS 3.0 Data Specifications will be implemented in October, 2011. This final version has	The change in the Medicare Short Stay assessment indicator logic with RUG-IV V1.01.1 only affects whether the short stay indicator is set and not whether an assessment is accepted or rejected by the ASAP system. The short stay logic change is to only set the indicator if A0310C = 1 (SOT OMRA) rather than if A0310C = 1 (SOT OMRA) or 3 (SOT and EOT OMRA). Actually, this coding change has NO impact on whether the indicator is set or not. Other requirements for a short stay assessment are: 4. The Medicare Part A covered stay must end on the assessment reference date (A2300) of the Start of Therapy OMRA. That assessment reference date must equal the end of Medicare stay date (A2400C). 6. Rehabilitation therapy must not have ended before the last day of the Medicare Part A covered stay. That is, at least one of the therapy disciplines must have a dash-filled end of therapy date (O0400A6, O0400B6, or O0400C6) indicating on-going therapy or an end of therapy date equal to the end of covered Medicare stay date (A2400C). These 2 requirements, taken together, mean that all therapy has not ended on the assessment ARD for an assessment to qualify for short stay. However, an EOT OMRA has an ARD 1 to 3 days after the last day that therapy was received and cannot meet these two requirements. An EOT OMRA can never qualify as short stay, and some developers had been confused by logic

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		been updated with the errata from version 1.01.1	allowing A0310C to equal 3 for a short stay. To avoid this confusion the logic change was made in V1.01.1 that A0310C must only equal 1 to qualify for short stay.
20110803-007	K-RUGs	The current changes in V1.01 RUG-IV specifications will not affect the State RUG-IV calculation results as the changes are applied to sRehabType =MCAR2 and States do not use the federally defined Assessment Indicator (where other major v1.01 changes occurred). So really, state RUG results are not affected by updated RUG-IV v1.01 calculation changes. The version code returned by the grouper is changed for all calls.	If the rule is finalized, the ASAP system will be using the new version 1.01 for re-calculating Z0200A and Z0250A; however as you note, that part of the code has not changed. State RUG calculations are always done with sRehabType = OTHER. This change will not affect the state RUG IV calculation results for the RUG IV group. It will affect the RUG IV version code returned by the grouper as this is a new version of the RUG IV grouper.
20110803-008	K-RUGs	For the states that use RUG-IV in Z0200 and/or Z0250 and have set up the RUG-IV score validate in the ASAP System, we will need to know the correct RUG-IV version that is being validated in Z0200B and Z0250B: As of Assessment ARD of 10/1/2011 what is the ASAP System expected State (Z0200B/Z0250B) RUG-IV version?	After the September 18, 2011 implementation of the ASAP, the ASAP system will use version 1.01 for all RUG IV calls (both CMS and state) sending the appropriate parameters based on the target date of the record and the CMS and state requirements. The version values for RUG IV version 1.01 are your selection b. 1.0166 1.0157 1.0148
20110803-009	K-RUGs	Will PPS assessments with a target date 8/22/2011 to 9/18/2011 that were already submitted and processed have their Validations Reports regenerated in order to display the transition FY2012 RUG?	No
20110804-010	K-RUGs	When the software calculates a rehab RUG score where only group minutes are entered: The facility enters the minutes unadjusted for group therapy. Does the software calculate the RUG based on the minutes entered, or does the software calculate the adjusted minutes first then calculate the RUG score? If the adjusted minutes are used to calculate the RUG score, when we tested our software updates (using the CMS dll), we are not getting the correct score. It's too high. Is there an error in the calculation for the updates effective October 1, 2011?	The group time is only divided by 4 if the rehabilitation type parameter (sRehabType) indicates classification for FY2012 Medicare (sRehabType = 'MCAR2'). The 25% group time limit is only applied if the rehabilitation type (sRehabType) indicates either FY2011 or FY2012 Medicare classification = 'MCARE' or 'MCAR2'. If the sRehabType is set to 'OTHER' (used for Medicaid in some states and other payers), then group time is not divided by 4 and the 25% group limitation is not applied. The DLL code was reviewed and no problems were observed. Records #14 and #15 in the test data file, Mcar2_rehab_Test_v1.txt, both have only 15 minutes of group time and the total adjusted time for Medicare (in this case sRehabType = 'MCAR2') is 0 for both records.

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20101220-014	K-RUGs	What are the parameters for calculating the Medicare RUG/HIPPS value on an MDS 3.0 assessment from a swing bed?	**RUG-IV Specifications and DLL Package (V1.02.0)** is located on the CMS MDS 3.0 Technical website http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html The download is RUG III files & RUG IV files. The RUGIV grouper overview in this download explains the calling the RUG dll. The RUGIV DLL user doc explains each parameter.
20101220-015	K-RUGs	When my MDS 3 software uses the RUG Version Converter and RUG III DLLs to get a grouper value, I keep getting BC1 for every assessment, while the ASAP gets a correct value. Why?	Many users that have configured their MDS 3 software to use the MDS3-to-MDS2 converter and RUG-III grouper DLLs for item Z0200 are submitting BC1 as a grouper result. A common software logic is: 1 - A 3690-byte fixed length format string for the assessment is generated, for the purpose of passing it to the RUG-IV DLL and the MDS3-to-MDS2 converter DLL. 2 -The RUG-IV DLL reported a correct grouper value. The MDS3-to-MDS2 converter DLL generated a corresponding 1814-byte MDS 2 fixed length string for the assessment without error. 3 -The RUG III grouper function in rug520.dll accepted the 1814-byte string generated in (4), but reported BC1 for the grouper value. NOTE: While the iError parameter for the RUG-III DLL returned a 0 (no errors), the overall function returned a 1, which indicates one or more of the RUG items was out of range. The MDS3-to-MDS2 converter DLL does not perform range checking of the input values. The fields in the 3690-byte fixed length format string containing the MDS 3.0 values were not formatted per the MDS 3.0 Data Specifications Overview pages 17 – 19 and so two fields, P7 and P8, were reported as out-of-range for containing the values 2 and 1, rather than 02 and 01 respectively. Review of the MDS 2.0 specs determined that the values were out of range because they were missing leading zeros. Vendors that are experiencing a BC1 issue and are using the converter and RUG-III DLLs are strongly encouraged to check their software to verify that the MDS 3 3690-byte

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			string contains leading zeros.
20101220-016	K-RUGs	Where do I find the RUG version code to submit in Z0100B, Z0200B and Z0250B?	The RUG version code required in the submission record is calculated and returned by the RUG-III or RUG-IV grouper, either the .dll or the SAS code in both cases. This information is found in the RUG specifications for the particular RUG system being used. This version is dependent on the RUG system (RUG III or RUG IV) and the model within a system (number of groups used). Z0100B and Z0150B: The first 3 characters of Z0100A and Z0150A are always a Medicare RUG-IV group code and the corresponding version code in Z0100B and Z0150B is "1.0066" as CMS uses the 66-group model. Z0200B and Z0250B: The RUG group reported in Z0200A and Z0250A can be RUG-III or RUG-IV as required by the specific state. If the state is using RUG-III, then the version code in Z0200B or Z0250B is "07" for the 44-group model, "08" for the 34-group model, and "09" for the 53-group model. If the state is using RUG-IV, then the version code in Z0200B or Z0250B is "1.0066" for the 66-group model, "1.0057" for the 57-group model, and "1.0048" for the 48-group model.
20101101-028	K - RUGS	We have clients who are not getting the short stay assessment with a Rehab RUG using Index maximizing. However, if we use Special Medicare, we are getting the short stay designation and the proper Rehab RUG score. If Index maximizing is the proper grouper, why are we not getting the proper RUG and short stay designation? What is the difference between the special Medicare and Index maximizing? We are using the new dll as provided by CMS.	A specific RUG-IV configuration includes ALL of the following settings: 1. Model: 66-group, 57-group OR 48-group. 2. Classification method: index maximizing OR Hierarchical. 3. Rehabilitation type: Medicare OR Other 4. If index maximizing, a CMI set must be set (there are different rural and urban sets for Medicare) The proper grouper for FY2011 Medicare must have Model = 66 groups, Classification method = index maximizing, Rehabilitation type = “MCARE” (Medicare) AND the E01 rural or E02 urban CMI set. The special Medicare short stay provisions is only in effect when Rehabilitation type = Medicare.
20101101-027	K - RUGS	It is my understanding that the Final Validation reports will give both the RUG III and the RUG IV value for accepted assessments. Can you please provide the criteria	RUG IV – The ASAP system calculates the Medicare RUG IV values for all assessments with the exception of records where A0310A = 99 and A0310B = 99. These recalculated

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		(specification) for a MDS 3.0 producing a RUG III value? Also, how long will the Final Validation report produce a RUG III and RUG IV value?	values are compared to the submitted Medicare RUG IV values in items Z0100 and Z0150. If any of the submitted items do not equal the recalculated value, the ASAP system sends a warning message that includes the item id, the submitted value and the recalculated value. If the submitted values match the recalculated values, then no message is sent. RUG III – The ASAP system also calculates the Medicare Transition RUG III for all assessments with the exception of records where A0310A = 99 and A0310B = 99. The ASAP system uses the CMS developed crosswalk software (a DLL) that translates the data in an MDS 3.0 record into MDS 2.0 format. The output from this software is then sent to the existing RUG-III grouper to obtain a RUG-III classification. The software and the specifications that were used to develop the DLL are posted on CMS's MDS 3.0 technical information web page. The Medicare Transition RUG III value calculated by the ASAP system will be provided on the Final Validation Report for records submitted with a target date between 10/01/2010 and 10/31/2010 (inclusive). Providers will see this information displayed in Warning message -1057 Medicare RUG III Transition RUG Calculated: A Medicare Transition RUG III was calculated for this assessment. This information can also be located in section 5 of the MDS 3.0 Providers User's Guide which is available on the QTSO website.
20101101-025	K - RUGS	If a state wants to use the “MCARE” rehab parameter for calculating RUGs, will the ASAP system recalculate Medicaid RUGs (Z0200 and Z0250) using the “MCARE” rehab option for calling the grouper?	No, the ASAP system will not use the ‘MCARE’ for the rehab parameter in calling Medicaid RUGs. A state can use whatever rehab parameter they choose to use. The discussion below describes what the ASAP system will do. If the state wants to do any other type of Medicaid calculation, the state must do that in their Medicaid system. It will not be done by the ASAP system. If the state wants the ASAP system to recalculate the Medicaid RUG values on an MDS 3.0 NP, NQ, or NC assessment, the state can set up the parameters in the MDS 3.0 DMS. This set up of parameters in the MDS 3.0 DMS will cause the ASAP system to recalculate the

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			Medicaid RUG submitted based on the parameters entered by the state into the MDS 3.0 DMS. The ASAP system only allows the state to choose the following parameters when having the ASAP system recalculate Medicaid RUGs 1 - Choose RUG IV version 1.00 model 66, 57 or 48 or RUG III version 5.20 model 53, 44, or 34. 2 - Choose a CMS defined CMI code set(s) or create a specific state defined CMI code set(s) for urban and for rural for the calculation. 3 - Choose the beginning and ending effective dates for which the Medicaid RUGS will be calculated. The target date of the assessment will be compared to the beginning and ending effective dates for the RUG calculation. If the target date is equal to or greater than the beginning date and equal to or less than the ending date, the RUG will be calculated. The state cannot choose the rehab parameter in the MDS 3.0 DMS. The ASAP system always uses "OTHER" for the rehab parameter in recalculating the Medicaid RUGs.
20101101-024	K - RUGS	My state is not having me submit Medicaid RUGs in Z0200 nor Z0250. Do I need to submit those items in my XML file?	The Medicaid RUGs items Z0200A, Z0200B, Z0250A and Z0250B are always active on NC, NQ, and NP assessments. As active items, these items must be included in your XML file with valid values. Per the MDS 3.0 Data Specifications, the valid values for these items are "TEXT" or "^". If the state requires the Medicaid RUGs item to be submitted, then the item value should be the appropriate RUG TEXT value. If the state does not require the Medicaid RUGs item to be submitted, then the item value should be a "^" (blank).
20101101-023	K - RUGS	What versions of the RUG DLLs should we use?	The most current versions should be used. The RUG documentation and DLLs are posted on the MDS 3.0 Technical website. As of 10/26/2010, the RUG IV Files link contains version 1.00.9 and the RUG III Files link contains RUG III converted specifications and DLL dated 10/22/2010. Please check this site frequently for updates

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20101101-022	K - RUGS	In a Skilled Nursing Facility, if a resident is on Medicare and is within their 100 days, and they are transferred to, and admitted to a hospital, upon return from the hospital without a new qualifying stay, do they continue their 100 days? Or are the days at the hospital counted towards their 100 days? For example, the resident is transferred to the hospital on day 5, comes back 5 days later. Are they then technically on day 6 at the SNF, or Day 10? I see a reference to a Swing Bed Hospital, but what about a regular hospital?	The Medicare Part A SNF benefit period limit of 100 days refers to covered days in a SNF. Days outside of the SNF do not count. The count resumes when SNF coverage resumes in a SNF. If the resident was discharged to a hospital after 5 covered days, returns to the SNF 5 days later, and Part A coverage resumes, then the count resumes at 6 days.
20101101-020	K - RUGS	The distinction for rural and urban, is urban over 10,000?	To distinguish between rural and urban you must use OMB's Core-Based Statistical Area (CBSA) definition. Facilities that are geographically located in a CBSA are urban, those outside of a CBSA are non-urban or considered rural (this includes Micropolitan Areas). CBSA's are established on a county level. The following OMB website gives the very latest information on any changes to the CBSAs. http://www.whitehouse.gov/omb/bulletins_default CMS tries to be very diligent about keeping up with the OMB definitions and a facility should be able to go to the FY '11 SNF wage index table A and look to see if their county is included in a CBSA. If so, they are urban. If not, they'll receive the rural rates and rural statewide average wage index. Here's a link for the FY '11 SNF Notice: http://edocket.access.gpo.gov/2010/pdf/2010-17628.pdf
20101101-019	K - RUGS	Can you confirm that SNF's are supposed to bill RUG IV as of 10-1-2010 on our Medicare Claims? That is, and has been, my understanding, at least, until further notice from CMS.	As of October 1, 2010, CMS has begun to reimburse SNF providers based on RUG-IV.
20101101-018	K - RUGS	Washington State is a Case Mix state with their own computation formulas for case mix weights. Washington does not distinguish between Urban and Rural. Washington has set up WA1 for the primary 57 Grouper and WA2 for the alternate 48 Grouper. Nursing Homes and Vendors want to know what to put in their systems. Would they use F02 and F01 to identify 57 and 48, or WA1 and WA2?	Facilities in Washington should use the state WA1 and WA2 CMI sets, not the F01 and F02 national sets.
20101101-017	K - RUGS	Could you explain the ASAP setups for the state with regards to validation of the state RUGs? Are the state options to validate or not validate or is there an option to validate if data	The ASAP system will validate the Medicaid RUG items (Z0200 and Z0250) on NC, NQ and NP ISCs if the state has set up the options to do the evaluation in the MDS 3.0

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		is present? If a facility submits a RUG in Z0200 or Z0250 and the state does not require submission does the ASAP RUG validation run based on the state setups in the ASAP system or does it run based on the presence of data.	DMS. If a facility submits a RUG in Z0200 and/or Z0250 and the state does not require submission based on the state setups in the ASAP system, then the ASAP system does not recalculate these values. Regardless of the flag, all "submitted items" are always saved as long as they are active for the ISC, and the assessment is accepted. For NC, NQ, and NP, items Z0200 and Z0250A are active so the submitted values are stored in the database regardless of whether the recalculation is done.
20100114-029	D - RAI Manual	I see a conflicting message on the ADLs. After the Rule of 3 discussions, it says if the activity did not occur 3 or more times, then code supervision. However, then I see a new code 7 to be used when the activity occurs only 1 or 2 times. These conflicts to me. Also, if you code a 7 in the score by frequency, how does that affect the total ADL score?	ADL score calculation was provided in the SNF PPS Final Rule, and in chapter 6 of the RAI manual (section 6.6), and in the RUG-IV SAS code. With the MDS 3.0 code 7 if the activity only occurred once or twice and code 8 if the activity did not occur at all. In calculating the ADL score, a code of 7 is counted as 0, along with 1 (independent), 2 (supervision), and 8 (activity did not occur).
20100114-028	D - RAI Manual	How is the total ADL score calculated? I found a RUG IV version of this but it was not an official document so I want to be sure.	ADL score calculation was provided in the SNF PPS Final Rule, in chapter 6 of the RAI manual (section 6.6), and in the RUG-IV SAS code, which are all available.
20100926-041	K - RUGs	Do we have a misunderstanding of the MDS 3.0 to RUG III regulations? It was our understanding that the states are not permitted to alter the RUG III crosswalk or code. We have just been notified by the State of Maine that they are going to create a hybrid RUG III calculation code for the state.	CMS does not dictate to States how to calculate their State reimbursement methodology or payment rates, including payment for Medicaid residents in a long term care stay in a nursing home. Since this is a "non-standard" use of the RUG calculation, the ASAP system will not recalculate the state Medicaid RUG (Z0200). Maine will have to do all recalculations on their own state Medicaid system. The current MDS 2.0 Medicaid RUG calculation settings for Maine have the "Calculate Medicaid RUG option" set to Y, but there are no RUG calculations entered, so the MDS 2.0 state system does not recalculate RUGs for Maine on the MDS 2.0 assessments.
20100926-040	K - RUGs	The RUG III mapping specs do not include a translation from MDS 2.0 I1cc Traumatic Brain Injury to MDS 3.0 I5500 Traumatic Brain Injury. Is there a reason this no longer is used in RUG III calculation?	The MDS 2.0 item I1cc (Traumatic Brain Injury) is not used by the RUG-III grouper. It is therefore not necessary to include a translation between I5500 and I1cc in the RUG-III mapping specs.
20100926-039	K -	If facilities performs an OMRA start of therapy PPS for a	The requirement is that a start of therapy OMRA must

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	RUGs	resident and that resident qualifies for multiple RUG scores (some rehab and some non rehab) after applying the CMI index maximizing logic the resident RUG score ends up being a non rehab score. After that we apply the logic that states that if the user is performing a OMRA start of therapy and a non rehab RUG score is achieved then we are to assign a default AAA RUG score. This issue is prevalent when the resident qualifies for a non rehab RUG that has a higher index value such as ES3 vs. RML, RHL, or RLX (assuming a Rural E01 CMI) Can you provide some clarification on what is desired in this case?	produced a Medicare index maximized RUG-IV classification in a rehabilitation plus extensive group or a rehabilitation group. This means that the Medicare classification in Z0100A must be a rehabilitation plus extensive group or a rehabilitation group. That classification is based on the 66-group model, the Medicare rehabilitation classification type, and the appropriate Medicare CMI set (E01 for rural and E02 for urban). If the Z0100A RUG-IV classification is a group below the rehabilitation category, then the record will be rejected by the CMS MDS 3.0 system.
20100926-038	K - RUGs	Our vendor members are in need of a decisive algorithm for the second digit of the HIPPS AI code (character 5 of the HIPPS code that contains the RUG rates in Z0100A and Z0150A) that accounts for all potential combinations of the assessment type fields (A0310A – A0310F). Many combinations of the A0130 fields are going to fall through this logic and get an “X”. If the B or F value is changed, the algorithm doesn’t work. Our vendor members would appreciate CMS’ recommendation on the criteria that produce a valid second digit of the HIPPS AI code. We appreciate your hard work and prompt response.	A decisive algorithm for the AI code is contained in the RUG-IV SAS code and the RUG-IV C++ code provided in the RUG-IV grouper package. The DLL in that package implements this algorithm. Note that there is no AI code for all combinations of the reason for assessment fields (A0310A - A0310F). A RUG code and an AI code are not computed for discharge or entry records. Also, all other combinations of A0310A - A0310F are not valid. Please consult the data submission specifications for the valid combinations. The AI logic will not work with an invalid combination. The AI code definition in Chapter 6 (July 2010 version) has two statements that are being changed. The changes are: CHANGE #1 On page 6-8, the assessment type description for a value of 6 for the first AI digit is: "OBRA assessment used for PPS (not combined with any PPS assessment) when Part A eligibility is unknown at time of assessment" This statement is being changed to: "OBRA assessment (not coded as a PPS assessment) " This allows the first digit of the AI code to be assigned as 6 to all OBRA assessments not also coded as a PPS

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			assessment. This applies to all assessments with A0310A = 01 - 06 and A0310B = 99. CHANGE #2 On page 6-9, the assessment type description for a value of 0 for the second AI digit is: "Scheduled PPS assessment not replaced by or combined with an unscheduled PPS assessment or an OBRA assessment used for PPS" This statement is being changed to: "Either a scheduled PPS assessment not replaced by or combined with an unscheduled PPS assessment OR an OBRA assessment not coded as a PPS assessment " This allows the second AI digit to be assigned as 0 for any scheduled PPS assessment OR any OBRA assessment not coded as a PPS assessment. Note that when the first AI digit is 6, the second AI digit will always be 0. SUMMARY With these two changes the AI code definition in Chapter 6 will allow correct determination of the AI code for all appropriate assessments.
20100926-037	K - RUGs	The NO, NS, NOD, and NSD forms do not have all of the RUG III, 5.20, 34 grouper RUG items. Do these forms have all of the RUG IV items?	OMRA assessments (NO, NOD, NS, and NSD) do not support calculation of RUG-III. The RUG-III/MDS 3.0 crosswalk logic explicitly states this. If an OMRA assessment is run through the RUG-III/MDS 3.0 crosswalk, the MDS 2.0 record that is produced will not support RUG-III. If this MDS 2.0 record is run through the RUG-III grouper, the grouper will not compute a RUG-III group. The reason that OMRA assessments do not support RUG-III is that they are to be used only for RUG-IV, SNF PPS purposes. The RUG-IV grouper does produce RUG-IV groups for NO, NOD, NS, and NSD. Start-of-therapy OMRAs (NS and NSD) are valid only if they produce a rehabilitation or rehabilitation-plus-extensive RUG-IV group. NS and NSD therefore do not contain all of the

ID	Topic	Question	Answer
			RUG-IV items. Instead they contain only those RUG-IV items that are required to produce rehabilitation or rehabilitation-plus-extensive RUG-IV groups. NO and NOD assessments, in contrast, contain the complete set of RUG-IV items and can produce any of the RUG-IV groups (including non-rehabilitation groups).
20100926-035	K - RUGs	We have a scenario in which we need clarification. A0310A = 99 A0310B = 07 A0310C = 1 We have a code for Z0100A = RMA02 But for the Non-Therapy calculation (Z0150A) we have hit a default rug condition (AAA) and so our value being calculated for Z0150A = AAA02. It is our understanding that if the RUG-IV group is AAA (default), then the AI code should be reset to 00. The v1.00.8 SAS code provided does this perfectly if the Medicare Part A RUG-IV group is AAA, but doesn't seem to do the same for the NT calculation. This is the code from the SAS file that does this. -------Copied from RUGIV V1.00.8.SAS------- *Reset AI code to 00 if RUG-IV group is AAA (default group); IF sRugHier = 'AAA' THEN sAI_code = '00';	A non-therapy RUG classification is not possible on a stand-alone start of therapy OMRA, because almost all of the items necessary for non-therapy classification are inactive. The grouper sets the non-therapy RUG group to AAA for a stand-alone start of therapy OMRA. However it does not adjust the AI-code. The AI-code describes the type of assessment based on reasons for assessment with a code of 02 for a standalone start of therapy OMRA. As a result, the non-therapy HIPPS code for a stand-alone start of therapy OMRA is AAA02. The "02" allows identification of the reason for the AAA group code. The other cases where the HIPPS code contains an AAA classification are: AAA (with a blank AI-code) -- when a grouper parameter is in error AAAX -- when the type of record does not support RUG classification (e.g. entry record) or there the combination of reasons for assessment is invalid. . AAA00 -- normal and non-therapy RUG for any start of therapy OMRA where the normal RUG was below the rehab groups AAA02 -- non-therapy RUG for a standalone start of therapy OMRA where the normal RUG was a rehab/extensive or rehab group AAA07 -- non-therapy RUG for a Medicare short stay assessment where the normal RUG was a rehab/extensive or rehab group It is useful to retain information concerning the cause for an AAA classification, rather than always resetting the AI-code 00 for any AAA classification.

ID	Topic	Question	Answer
		---------- The NT calculated group is set in a variable sRugHier_NT not in sRugHier. Is there supposed to be only one AI calculation that gets set as part of both Z0100A and Z0150A (as we have currently), or should the code be independent and have separate reset conditions for each calculation?	
20100926-034	K - RUGs	Chapter 6: Medicare SNF PPS refers to Category III: Extensive Services, RUG-IV, 66-Group as RUG-IV Classes of “ES” but one of my staff believes they are really “SE” which is what I see in Quality. He thought that “ES” in the manual was a typo… Do you know if it is “SE” or “ES”?	Chapter 6 of the RAI manual is correct in labeling the RUG-IV Extensive Services groups as ES1, ES2, and ES3. These groups are incorrectly labeled as SE1, SE2, and SE3 in three places in the RUG-IV V1.00.8 grouper documentation as follows: In Table 5-1 of "RUGIV grouper overview V1.00.8 20100817.PDF" In Table 2 of "RUGIV DLL user doc V1.00.8 20100817.pdf" In Table 2 of "RUGIV SAS user doc V1.00.8 20100817.pdf" The correct group labels are ES1, ES2, and ES3. An errata to RUG-IV V1.00.8 was posted indicating the errors in the three documents.
20100926-033	K - RUGs	If we are a case-mix state and have values in DMS for state primary and alternate RUG groups, will the system compute the Medicaid RUGs?	Whether the ASAP system recalculates the Medicaid RUG values depends on the requirements of the state. If the state requests the ASAP system to calculate Medicaid RUGs, then the ASAP system will recalculate the Medicaid RUG values and send warnings when the submitted value does not match the recalculated value. States may request the ASAP system to recalculate the Medicaid RUG Z0200 and/or Z0250 items. The ASAP system only calculates standard RUG III V5.20 and RUG IV V 1.00 calculations. The state may require providers to submit values in Z0200 and/or Z0250 items without requesting the ASAP system to recalculate these values. In this case the ASAP system stores the values submitted, but does not do any recalculation. States that use non-standard RUG calculations will not use the ASAP system to do any recalculation.
20100926-032	K -	The DMS will allow the state to set up a Medicaid RUG	If you are using RUG-III, version 5.12, and the B01 CMI set

ID	Topic	Question	Answer
	RUGs	calculation. The DMS Webex display did not include the RUG version of B01 and B02 will these versions be available in the DMS 3.0? If not, what version in the 5.20 is equivalent to the 5.12, B01, 34 group?	for MDS 2.0, the equivalent MDS 3.0 settings are RUG-III version 5.20, 34-groups, and the D01 CMI set.
20100926-030	K - RUGs	I have the returned data from the RUG calculations and would like to know what returned calc values are used to populate all the Z fields: Z0100a,b,c, Z0150a,b, Z0200a,b, Z0250a,b and Z0300a,b. I do understand that the RUG code returned and the AI code are combined and placed in the fields. I just don't know which one.	The RUG IV documentation located on the CMS technical website: http://www.cms.gov/nursinghomequalityinits/30_nhqimds30technicalinformation.asp explains the RUG IV calculations. The following relates the parameters returned by the RUG IV code to the items on the MDS 3.0 item set. Medicare (RUG IV) returned grouper items when RUG IV call did not return an error. Z0100A = sRugMax concatenated with sAI_code Z0100B = sRugsVersion FYI - Only current value for Medicare is “100-66” Z0100C = l_Mcare_short_stay If A0310C = 1 or 3, then if the first character of C_MDCR_HIPPS_TXT is not equal ‘R’, then the SOT assessment did not produce the required rehab group. Z0150A = sRugMax_NT concatenated with sAI_code Z0150B = sRugsVersion State Medicaid (RUG III or RUG IV per state option) returned grouper items when RUG III call did not return an error. RUG IV MDS_RUG_CLSFCTN_TYPE_CD = INDEX Z0200A or Z0250B = sRugMax Z0200B or Z0250B = sRugsVersion If MDS_RUG_CLSFCTN_TYPE_CD = HIER Z0200A or Z0250A = sRugHier Z0200B or Z0250B = sRugsVersion RUG III If MDS_RUG_CLSFCTN_TYPE_CD = INDEX Z0200A or Z0250A = cRugMax Z0200B or Z0250B = cRugVersion If MDS_RUG_CLSFCTN_TYPE_CD = HIER Z0200A or Z0250A = cRugHier

ID	Topic	Question	Answer
			Z0200B or Z0250B = cRugVersion
20100926-028	K - RUGS	Where can we obtain a sample of a RUGIV fixed format MDS 3.0 string that will successfully convert to a MDS 2.0 format string via the converter dll that will also be compatible with the rug520 and rug512 grouper libraries?	Test flat file strings containing the required RUGs items are available with the MDS 3.0 to MDS 2.0 RUGs conversion .DLL and documentation contained in the RUGIII files & RUG IV file download. This is available for download at http://www.cms.gov/nursinghomequalityinits/30_nhqimds30technicalinformation.asp website. Please note that these test files only contain the RUGs items and will not pass all of the MDS 3.0 Data Specifications for submission files.
20100926-027	K - RUGS	There is a qualification if the assessment is coded as a Start of Therapy assessment (A0310C = 1 or 3) that is providing an issue when the grouper is used to calculate a State Medicaid Score. RUG-IV Pseudo Code has an adjustment in RUG group for a start of therapy OMRA (A0310C = 1 or 3). By defaulting the RUG calculation to the default "AAA" score if there is not a rehab based score works fine if you are only looking at the Medicare RUGs Calculation. The process is sound as the facility would need to remove the Start of Therapy reason in order to submit the assessment and have it pass submission validation. But this code is not valid for states that choose to use the RUG-IV grouper, it is defaulting the State RUG score to "AAA". We have run into test cases using the draft version of the E01, E02 CMI sets handed out at the Las Vegas CMS MDS 3.0 training where the calculated Medicare RUG is a Rehab based score but the default RUG-IV CMI sets (F01, F02, F03) do not calculated a rehab based RUG so the score is being defaulted to "AAA". Case= RUG 66 Model using F03 CMI Set Section O01002- E=1 and F =1, O0400A1 = 500, O0400A4=5 ADL=5. The Medicare Score is a RVL, Medicare Non-Therapy = ES3. When the RUG-IV is using the default CMI Set F03 (Nursing-Only, no Rehab taken into account in the CMI set) the correct score is ES3 which trumps any Rehab based score. This is true of the F01, and F02 sets as well; ES3 trumps any Rehab based score. So if a State is using the RUG-IV 66 or 57 or 48 groupers they will get a default AAA by the RUG-IV logic being applied.	CMS policy is that a Start of Therapy OMRA assessment is only valid if it produces a Medicare index maximized RUG-IV classification of Rehabilitation Plus Extensive or Rehabilitation in item Z0100A. Start of Therapy OMRAs that produce a lower RUG-IV classification in Z0100A are considered to have a fatal error and are rejected by the CMS MDS 3.0 system. Such records, like all other rejected records, are not in the CMS MDS 3.0 database and will not be available to the states for Medicaid rate calculations. CMS has no plans to change this policy and no revisions to the RUG-IV grouper are necessary.

ID	Topic	Question	Answer
		Will CMS be updating the RUG-IV grouper (and associated DLLs) to have a variable added to it so this logic can be bypassed if the States deem it necessary?	
20100820-047	K - RUGS	I could not answer the question about “calculations for 66 groups which is translated easily to the 57 group but not to the 48 group”	Currently, the only documentation for the RUG-IV 48 and 57 group models is in the RUG-IV SAS code and C++ code in the Grouper Package. Here is a quick description. 57-Group Model. To achieve the 57 group models: 1. Simply leave out the 9 Rehabilitation/Extensive groups from the 66-group model. 2. Begin classification with the Ultra High Rehab category 3. Proceed with Extensive Services and the lower classifications in the normal way. 48-Group Model. To achieve the 48-group model: 1. Leave out the 9 Rehabilitation/Extensive and the following 14 Rehabilitation groups from the 66-group model. 2. Start with the Extensive Services groups. 3. After the Extensive Services groups, check to see if the resident would qualify for the 66-group Medium or Low Rehabilitation categories as follows: a. If total therapy minutes (across Speech, OT and PT) are greater than or equal to 150 and the total days of therapy (across Speech, OT and PT) are greater than or equal to 5 OR b. If total therapy minutes (across Speech, OT and PT) are greater than or equal to 45 and 2 or more restorative nursing services received for 6 or more days. If either a or b is true, then the resident qualifies for a 48-group Rehabilitation group based on ADL score as follows: RAE if ADL score is 15-16. RAD if ADL score is 11-14. RAC if ADL score is 6-10. RAB if ADL score is 2-5. RAA if ADL score is 0-1. 4. Proceed with Special Care High and the lower classifications in the normal way. Note that the 57-group classification for RUG-IV mirrors the 44-group classification for RUG-III and the 48-group

ID	Topic	Question	Answer
			classification for RUG-IV mirrors the 34-group classification for RUG-III. There are classification worksheets for the RUG-III 34- and 44-group models at: http://www.cms.gov/MDS20SWSpecs/12_RUG-IIIVersion5.asp#TopOfPage
20100820-043	K - RUGS	Do you happen to know where you can determine what type of rehab should be used when figuring the RUG IV? That parameter is passed in and it is expected to be other or mcare, but I do not see where this value is specified in MDS 3.0. In 2.0 there was a question about Ordered Therapies and that is what was used to determine what Rehab Type was passed in. Since they are doing the Z0100A and Z0150A does that mean that passing in the RehabType to the RUG dll's is obsolete, since when using RUG IV you get the Medicare Rate and the Non-Therapy Rate? How would this effect the RUG III calculation, this should mean that the RehabType passed into it is always Other, correct?	For Medicare calculations, the ASAP system always sets the rehab type to MCARE for FY2011 (October 1, 2010 – September 30, 2011) and MCAR2 for FY2012 and beyond (October 1, 2011 – until changed) (Z0100, Z0150 and the transition RUG III). For state Medicaid calculations the ASAP system always sets the rehab type to OTHER (Z0200A, Z0250A).
20100820-027	K - RUGS	Please clarify the calculation of the sRUGHier_NT, when the assessment is a SOT or SOT/EOT not combined with OBRA or other PPS. However, I would expect that the Non-Therapy RUG would be a nursing RUG to allow for the billable days outside of the therapy date range. Specifically, I would expect the SOT to provide a nursing RUG for the days prior to start of therapy and the EOT to provide a nursing RUG for the days after therapy. The RUG IV v1.00.6 section Adjustment in RUG group for a start of therapy OMRA (A0310C = 1 or 3), per the code If start of therapy OMRA gives a 66-group index maximized Rehabilitation Plus Extensive Services or a Rehabilitation Group and is not combined with OBRA or other PPS assessment then reset all non-therapy RUG results to the AAA default group. "ELSE IF ((A0310A = '99') AND ((A0310B = '99') OR (A0310B = '07')) AND (A0310D NOT = '1')) THEN DO; sRUGHier_NT = 'AAA';	A start of therapy assessment cannot be used to establish a non-therapy RUG for billing the days prior to start of therapy. SNF PPS Policy is that a start of therapy OMRA only influences billing from the start of therapy services forward. The days prior to the start of therapy must be billed based upon another PPS assessment that established a billing rate for those prior days. This other assessment may be combined with the start of therapy OMRA. If there is no other PPS assessment establishing a billing rate for those prior days, then those days cannot be billed. Given this policy, it is appropriate that the RUG-IV grouper set the non-therapy RUG classification for a stand-alone start of therapy OMRA (not combined with another OBRA or PPS assessment) to the AAA default group. An end of therapy OMRA establishes a non-therapy RUG for billing days starting with the day after therapy ended. A non-therapy RUG is therefore necessary for an end of therapy OMRA. For an end of therapy OMRA combined with a start of therapy OMRA, the Rehabilitation/Extensive or Rehabilitation classification is needed to bill days from the start of therapy date through the last day of therapy and the non-therapy RUG is needed to bill from the day after

ID	Topic	Question	Answer

		nRugHier_NT = 72;
		sRUGMax_NT = 'AAA';
		nRUGMax_NT = 72;
		
		So when the following is true:
		A0200 = 1
		A0310A = 99
		A0310B = 07
		A0310C = 1
		A0310D = ^
		
		AND the normal RUG result is [R], it appears that the code requires the non-therapy RUG to be AAA when it should be a 66-Group code that is NOT [R].
			therapy ended forward. Version 1.00.6 of the RUG-IV grouper (the last public version) inappropriately sets the non-therapy RUG to the AAA default group for a start of therapy OMRA combined with an end of therapy OMRA. In this case, the non-therapy RUG is needed for the end of therapy OMRA billing of days after therapy ended. Version 1.00.8 corrects this problem and does not reset the non-therapy RUG to the AAA default group for a start of therapy OMRA combined with an end of therapy OMRA.

20100820-025	K - RUGS	My understanding was we have to be calculating RUG IV for 10/1/2010. I spoke with the Stat of GA this afternoon and they tell me GA will be continuing with RUG III. Can you provide any help and guidance on this? Based on the information I have read, and you seem to confirm it, It appears we can transmit RUG-IV, regardless of state, and the QIES MDS 3.0 ASAP System will convert the submission for the relative state, which means we only need be concerned with calculating RUG-IV? Or do we need to calculate both?	The QIES MDS 3.0 ASAP System will support both RUG-IV for Medicare and RUG-III version 5.20 for Medicaid. States have the option to remain with RUG-III classification and RUG-III will be a permanent feature of the MDS 3.0 system. The ASAP system will recalculate the state RUG values only if the state requests the ASAP system to do so and the state uses one of the 2 supported groupers above. The vendor needs to always submit RUG IV for the Medicare RUG items (Z0100 and Z0150). If GA is using RUG III and having the ASAP system recalculate the state RUG values (Z0200 and/or Z0250), then the vendor should be submitting the appropriate RUG III in the appropriate item(s) per GA. GA should be notifying their vendors of their RUG Version (ie RUG III Version 5.20), RUG model (34, 44 or 53 for RUG III version 5.20) to be used for the state calculation(s). If a RUG item is active on the ISC but not submitted, the assessment will be rejected as missing the item. If the item is submitted as a blank or the value does not match the recalculated value, the assessment will get a warning message.
20100820-023	K - RUGS	Are there RUG test files?	RUG test files are available in the RUGIII files & RUGIV files download on the CMS MDS 3.0 Technical Information website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30Technic

ID	Topic	Question	Answer
			allInformation.html .
20100820-022	K - RUGS	Is there SAS code on the CMS site for this conversion?	There is no SAS code for the conversion of MDS 3.0 items to the MDS 2.0 items needed for RUG-III. However there is a "RUG-III MDS 3.0 Mapping Specifications document that includes a "Logic" section for each MDS 2.0 RUG-III item. This "Logic" is actually tested Visual Basic code and one should be able to convert this to SAS code. This document is available from the CMS MDS 3.0 Technical Information website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html .
20100820-021	K - RUGS	Will MDS 3.0 data be 'backwards compatible' that is, can MDS 3.0 data be used for RUGS-III?	RUG-III may be determined based on MDS 3.0.
20100820-020	K - RUGS	The programmer assigned to this project has run into some errors with the RUG Version Converter that CMS has on their website. The programmer needs the code to connect with the .DLL to convert the MDS3.0 data to MDS2.0 data. When the Demo RUG Version Converter for .NET is accessed, it is giving an error when an attempt to open it for testing occurs. The error says the project file is invalid. The following attachment is a copy of the first error. -- It basically reads that a section. <<MDS 3.0 CALCULATOR - ERROR 1.doc>> The programmer then went to the solution file to find the solution to this error edit and received a second error. Attached in this second attachment. <<MDS 3.0 CALCULATOR - ERROR 2.doc>> This error basically reads that the programmer needs a newer version of Visual Studio to open this file. So we need to know in which version of Visual Studio did CMS create this demonstration program. When I checked the properties of the files on the ZIP file, it did not give this information.	Visual Studio 2008 was used for the .NET demo.
20100820-019	K - RUGS	How would we calculate PA RUG score using CMSs supplied DLLs since they are using the RUG III 5.12 44 grouper calculation? Would we use the RUGIII converter and then the 5.12 DLL or the 5.20 DLL? For MDS 2.0, we used our own calculator to come up with the score, but for the new MDS 3.0, we are trying to make it a little easier on ourselves.	Use the 5.20 DLL. There is no DLL for the 5.12 version. Using the 5.20 DLL should not lead to different 44-group classifications than your custom 5.12 version application, as long as your custom application strictly mirrored the logic in the CMS 5.12 version code.

ID	Topic	Question	Answer
			Please note that the CMI array has 49 elements for 5.12 but 58 elements for 5.20 (the additional 9 elements corresponding to the additional 9 Rehabilitation/Extensive groups added with the 53-group model).
20100720-053	K - RUGS	Will the recalculated value for Z0100A be returned for all assessments or only for all PPS assessments or for only the PPS assessments where the recalculated value does not match the Z0100A submitted value?	The recalculated value for Z0100A will be calculated for all assessments except for assessments where A0310A and A0310B both are equal to 99. The recalculated value for Z0100A is only returned if it does not match the Z0100A submitted value (this includes if blank is submitted). It is returned when the values do not match on all assessments that have Z0100A recalculated.
20100720-033	K - RUGS	What values belong in the following "RUG version code" fields on section Z: Z0100B, Z0150B, Z0200B, Z0250B, Z0300B	The RUG version code field depends of the version of the RUG Calculated in the corresponding Z field. RUG IV version codes are documented in the RUG documentation cited above. RUG III version codes are the same ones that you are currently calculating for MDS 2.0. The only RUG version supported are RUG IV Version 1.00 and RUG III Version 5.20. The RUG III information is in the download RUG-III Version 5.20 (ZIP 1.4MB) on the CMS website: http://www.cms.gov/MDS20SWSpecs/09_RUG-IIIVersion520.asp#TopOfPage sRugsVersion is a string variable which returns the Logic Version code of the RUG-IV classification which was used. This version code will be the RUG-IV Logic Version (“1.00”) plus the Model (“66”, “57” or “48”). An example version code is “1.0066”. This version code is recorded on the MDS at items Z0100B and Z0150B. Z0300B is for the facility’s use only and is not submitted to CMS.
20100720-032	K - RUGS	The Medicare calculated RUG rate and HIPPS code belongs in field Z0100A, while the Medicaid RUG rate and HIPPS code belongs in Z0200A. We are unclear as to the population of Z0150A, Z0250A, and Z0300A? Do they use a RUG calculation algorithm different from what is detailed in chapter 6 of the RAI manual? Are there separate groups of RUG indices?	Z0150A is the non-Therapy Medicare RUG. This is documented in the RUG IV documentation location on the CMS website for MDS 3.0 Technical Information: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation.html. You can get more information on Section Z in Chapter 3 of

ID	Topic	Question	Answer
			the MDS 3.0 Manual and the Instructor Guide for the items located on the CMS website for MDS 3.0 Training Material: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html. Z0250A is the alternate state Medicaid calculation. States can choose to have 2 RUG scores calculated (Z0200A and Z0250A). You need to find out from the state if they are using Z0250 and if so, what version of the RUG should be calculated for Z0250. Z0300 is not submitted to the ASAP system. It was added as a convenience for the facility. CMS does not support Z0300.
20100720-027	K - RUGS	Am I correct that Z0100A is always populated and that when Z0100A represents a non-therapy code that code will also appear in Z0150A, but when Z0100A represents a therapy RUGS code Z0150A will be populated with a non-therapy RUGS, ignoring the therapies used to calculate the therapy RUGS in Z0100A.	This assumption is correct. Z0100A always contains the normal Medicare HIPPS code including a normal RUG code (can be therapy or non-therapy group). Z0150A always contains a Medicare HIPPS code restricted to non-therapy groups (classification made discounting any therapy). Note that these values are expected on OBRA assessments in addition to PPS assessments. In some cases, an OBRA assessment can be used for Medicare PPS billing (when Part A coverage was not initially known). Also, there may be cases where both the normal HIPPS code (Z0100A) and the non-therapy HIPPS code (Z0150A) from the same assessment are both used for Medicare billing. This can happen if a PPS 5-day assessment is combined with an end of therapy OMRA. In this case the normal HIPPS code (Z0100A) is billed for day-1 through the day that all therapy ended and the non-therapy HIPPS code (Z0150A) is billed starting on the day after all therapy ended. See the AI coding section in Chapter 6 of the RAI manual or the SNF provider manual for more detail.
20100720-026	K - RUGS	The spec for the 2nd digit of the HIPPS AI code on page 6-9 of the RAI manual seems to allow for many assessment type combinations to fall through the logic without qualifying for any of the listed code values. An example of section A values that result in this, as I understand it, is listed below:	The example given is for a nursing home (A0200 = 1) OBRA admission assessment (A0310A = 01) combined with a 5-day PPS assessment (A0310B = 01) and no OMRA assessment (A0310C = 0).

ID	Topic	Question	Answer
		A0200 = 1 A0310A = 01 A0310B = 01 A0310C = 0 A0310D = ^ A0310F = 99 Can you please indicate what the code should be for the second digit of the HIPPS AI code for the above assessment type combination, and why?	The first AI digit indicates the type of PPS scheduled assessment and will be a 1 since this is a 5-day assessment (see Table 2 on Page 6-8 – Chapter 6 of the MDS 3.0 RAI Manual). The entry for the second AI digit indicates if the assessment is an unscheduled PPS assessment or an unscheduled OBRA assessment used for PPS. As indicated on Page 6-8, the unscheduled PPS assessments are the OMRA assessments (indicated by A0310C = 1,2,3). The unscheduled OBRA assessments used for PPS are the significant change assessment (indicated by A0310A = 04) and significant correction of prior comprehensive (indicated by A0310A = 05). Since this assessment is a scheduled PPS assessment but not also an unscheduled PPS assessment or unscheduled OBRA assessment used for PPS, the second AI digit will be 0, as stated in the first row of Table 3 on Page 6-9:"Scheduled PPS assessment not replaced or combined with an unscheduled PPS assessment or OBRA assessment used for PPS". The only time that the second AI digit will not be 0 is when the assessment is a PPS OMRA, OBRA significant change, or OBRA significant correction of prior comprehensive.
20100225-041	K - RUGS	The items used in the RUG-III calculations: . T1b – Ordered Therapies . T1c – Ordered Therapies – estimated days until day 15 . T1d – Ordered therapies – estimated minutes until day 15 According to the mapping specs these do not have an MDS 3.0 item to support the data but there is no explanation of how a user/vendor will capture this information in order to perform the required calculations. Will these items be part of the Section S items that states, who need to collect the data to support their RUG model, will be able to select for inclusion?	The purpose of the ordered therapy items on MDS 2.0 and RUG-III was to project therapy usage at the beginning of Medicare stays. The concept of projecting therapy usage with the ordered therapy items is not used in RUG-IV and has been replaced with the special calculations that can be applied to short stays. Because this concept is not used for RUG-IV, the ordered therapy items were not added to MDS 3.0. Ordered therapy therefore cannot be used to make RUG-III calculations from MDS 3.0.

ID	Topic	Question	Answer
20100225-035	K - RUGS	Chapter 3 - Section Z - Assessment Administration Nov 2009.pdf (Page Z-1) makes reference to a HIPPS code link as can be seen below: • The HIPPS code is a Skilled Nursing Facility (SNF) Part A billing code and is composed of a three-position code representing the RUG category label, plus a two-position assessment type indicator. For information on HIPPS, access: http://www.cms.hhs.gov/ProspMedicareFeeSvcPmtGen/02_HIPPS CODES.asp#TopOfPage As a vendor, are we to continue using the existing "Definition and Uses of HIPPS Codes" (3/17/2008 Version 4) document that we've been using for MDS 2.0 or will there be updated HIPPS code document provided specifically for MDS 3.0?	The HIPPS codes have been completely revised for MDS 3.0 and RUG-IV. The HIPPS Code Master List referenced below will be updated in the future as needed. Chapter 6 of the RAI manual discusses the new HIPPs codes for MDS 3.0/RUG-IV. A vendor should be able to determine the HIPPS code from the information in Chapter 6.
20100225-024	K - RUGS	Just to confirm. I assume that since Z0300 fields for Insurance Billing are not in the data specs that CMS is not collecting that information and therefore does not care how they are used.	The Z0300 fields are for the use of the facilities. The items are not submitted to CMS and so are not listed in the detailed specifications. Similarly Z0400A – L, the signatures are on the printed items sets but are not in the data specs and are not submitted to CMS in the submission record.
20100114-036	K - RUGS	Will both RUG III and RUG IV systems need to be maintained for a period of time once RUG IV is in place?	The QIES MDS 3.0 ASAP System will support RUG-IV Version 1.00 for both Medicare and Medicaid and RUG-III version 5.20 for Medicaid. States have the option to remain with RUG-III classification and RUG-III will be a permanent feature of the MDS 3.0 system.
20100114-035	K - RUGS	Is implementation of RUG IV payment system still planned for October 2010 or has it been delayed to October 2011? If it is delayed until October 2011, what is the interim plan for RUG III payment system under the MDS 3.0 umbrella?	RUG IV payment began October, 2010
20100114-020	K - RUGS	How will this affect RAI chapter releases dealing with RUGs? Will RUG III be modified to handle the change in concurrent minutes or will this change simply modify the total minutes passed to RUG III? Likewise if Extensive service look-back is changed will all the RUG III extensive services be retained for RUG III calculations? If RUG III remains for Medicare PPS FY2011 with changes in therapy minutes and extensive services will CMS then adjust the rates and Case Mix index to be budget neutral as planned for RUG IV implementation? Does this change mean that the MPAF/Quarterly would change?	For use in state Medicaid systems, the current version of RUG-III (Version 5.20) will remain the same using total therapy minutes and both pre-admission and post-admission extensive services. The MDS 3.0 PPS/Quarterly item subset will not change. That item subset contains all the items necessary for RUG-III and RUG-IV.
20111110-014	L-ASAP	How is the 92 days being calculated, is it from the ARD field	The timing of OBRA assessments is from ARD to ARD.

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		or ZO500 field? We are receiving late assessments. We also have set are dates ahead so we should never be late. This has just started in the last couple of months. Never has happened before. We are set at 85 days and 360. Also, we have spoken with our vendor who said that it's a state issue.	Z0500 is not used for timing of assessments. Please refer to Chapter 2 of the RAI Manual posted on the CMS website: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html. This is described in the chart on pages 2-15 and 2-16, discussed in 02 on pages 2-19 -2-20 for Annual assessments and in 05 on pages 2-30 and 2-31 for Quarterly assessments.
20111110-015	L-ASAP	Until late September, our software did not trigger CAT20 automatically based on Q0600, allowing users to submit any value, and there were no rejections because of that. All of a sudden, our clients started getting rejections when they submitted Q0600 = 1 and CAT20 = 0 (and opposite). Has something has been changed in the ASAP system, and the CAT20 started to be validated? Our question is: should CAT20 be triggered based on Q0600 (that means it is covered by ASAP validation process) or it can be submitted as any allowed value?"	The fatal edit for CAT 20 went into effect in the ASAP system on 9/22/2011 with the new release for October 2011. A comprehensive assessment will be rejected if the values of Q0600 and CAT20 are inconsistent. If Q0600 = 1 then CAT 20 must be 1 if Q0600 does not = 1 then CAT 20 must be 0. This edit will be enforced for all assessments **submitted** after the 9/22/2011 QIES system downtime.
20101220-017	L-ASAP	If the first or last name are too long for the maximum length of the field, will we get the -3793 format error or a message that you can't find a match for that name?	If the name is too long, the system will issue format error -1003. If the system can't find the resident using the information sent in Section X, then the modification will be rejected with an error -3745 No Match Found.
20101220-018	L-ASAP	What characters will be accepted in the file name.	Only printable ASCII characters, except apostrophes are accepted in the file name. Do not use an apostrophe as a character within file name.
20101220-019	L-ASAP	Someone mentioned a character limit on name of the zip file.	It is 260 characters including the extension. The same character limit applies to names of xml file names. This information is in the MDS 3.0 Data Specifications Overview.
20101220-020	L-ASAP	In what order are records on the final validation reports sorted? They are not in xml order, alpha order, ISC order, or date order.	The ASAP system sorts assessments in advance of processing because it is possible to receive original records and corrections to the originals in the same zipped file. In order to avoid rejecting the correction, we sort before processing. We use the same sort order as used in MDS 2.0.

ID	Topic	Question	Answer
			The records in the zip file are processed based on the following criteria: State code (STATE_CD) ascending. Facility ID (FAC_ID) ascending. Target date (TARGET_DATE) when X0100 = 1 or Attestation date (X1100E) when X0100 = 2, 3 ascending. Entry/discharge code (A0310F) ('01' values first, '10', '11' or '12' values last and all other codes ('99') will come in between). Correction number (X0800) ascending. For the automatically generated Final Validation Report the ASAP system does the following: Record sorting order – Assessment records for the facility will be sorted in the order they were processed (see above sort order). Error detail sorting order – Multiple errors from same assessment will be displayed by listing FATAL errors first in the alphabetic order of item names, and then listing all WARNINGs in the alphabetic order of item names in errors. Values in the item in error field will be used for alphabetical ordering of both FATAL and WARNING error details for any assessment in validation report.
20100926-045	L - ASAP	I have been getting inquiries from a nursing home saying that they have been receiving conflicting information regarding whether or not facilities will need new passwords for submission of MDS 3.0 documents. Can you please clarify whether or not new passwords will be required or if the transition for submission will be the same as it is for the MDS 2.0?	A single user ID and password will be used to access both the MDS 2.0 and MDS 3.0 submission systems and CASPER Reports. The individual user ID and password currently used to access the MDS 2.0 submission system and CASPER Reports, will be the user ID and password used to access MDS 3.0.
20100926-044	L - ASAP	Can you submit more than one MDS record for the same person within one zip file?	A provider can submit more than one record for the same person in the same .zip file. Processing Order of records in a single zip file: Within an MDS 3.0 zipped file, records are sorted using the same sort as MDS 2.0 records were sorted in their submission file. The records in the zip file shall be processed based on

ID	Topic	Question	Answer
			the following criteria: 1. Sort records by state code 2. Facility ID 3. Target date* (for new data records [X0100 = 1]) or X1100E – Attestation date (for correction records [X0100 = 2 or 3]); 4. If two records have the same target date (or X1100E for correction [X0100 = 2 or 3]), then records where A0310F = 01 (Entry record) are processed first; records where A0310F = 10, 11 and 12 (discharge records) are processed last and all other records are processed in between. 5. If two corrected records have the same attestation date, then sort the records in ascending order by correction number. If multiple records for the same resident are to be transmitted at the same time, they should be included in a single zip file.
20100926-043	L - ASAP	Will the Final Validation report warning -1057 show the entire RUG III and RUG IV HIPPS code or just the RUG?	Yes, the RUG III code will be provided with Warning message -1057 on the Final Validation report for assessments with target dates 10/01/2010 – 11/01/2010 and whose A0310A and A0310B values are not equal to 99,
20100926-042	L - ASAP	I was wondering if submissions done either on Saturday or Sunday would be appropriate. If so, will there be a 48 hour wait to get the MDS 3.0 validated? I've been hearing that facilities should not submit on Thursday afternoons through Friday afternoon because of the large number of facilities submitting and validations could be held up for as long as 48 hours.	Providers can submit on weekends. Submissions should be processed within 24 hours. If your submission has not been processed within 24 hours, please call the QTSO help desk. The number of submissions received and waiting to be processed will affect how quickly a submission is processed. Submissions are processed in the order received. Providers may try different submission times ("off hours") such as nights and weekends if desired. The system is available all days, all hours, except for the QIES down times (system downtime 2nd Saturday of the month, QIES downtime 3rd Sunday of the month). At these down times, providers will not be able to submit files. These are the same down times as for the MDS 2.0 submission

ID	Topic	Question	Answer
			system.
20100820-036	L - ASAP	Will any MDS 3.0 documents (validation reports, QI/QM, provider reports, etc.) be published to the state site facility folders where the MDS 2.0 final validation reports are found currently?	The MDS 2.0 final validation reports will continue to be stored in the current state site facility folders when MDS 2.0 records are submitted. The scheduled reports for MDS 2.0 have been discontinued. The QI/QM reports are in CASPER not in any state site facility folders.
20100820-035	L - ASAP	Which file format(s) will be provided via CASPER for the NH Final Validation Report and Submitter Final Validation Report? If the text-only format will not be provided via CASPER, where will it be provided?	The facility Final Validation report can be obtained in two ways, the automatically generated text file report or by the facility user running a facility Final Validation report. 1 - The automatically generated Facility Final Validation Reports are text files, not PDF files. The Final Validation Reports will be located in CASPER in the facility's final validation report shared folder titled NH st fac_id VR where st is the 2 character state code of the state of the facility and the fac_id is the facility id of the facility. This is the same fac_id that is used to submit MDS 2.0 records and MDS 3.0 records. It is located in the control section as item FAC_ID. The access to the Facility Final Validation Reports is very similar to accessing the MDS provider Five-Star reports only in a different shared folder in CASPER. Accessing the MDS 3.0 Facility Final Validation Report is different than the way it was done in the MDS 2.0 system. A sample file can be found on the MDS 3.0 Technical website http://www.cms.gov/NursingHomeQualityInits/30_NHQIMDS30TechnicalInformation.asp#TopOfPage Click on MDS 3.0 Sample Item Sets and XMLs V1.00.2 07-26-2010. Click on the file 07082010143808.txt 2 - If a generated Facility Final Validation report is no longer available in the shared folder as it has exceeded the report retention period and been deleted (> 60 days), the facility user may request the report through the CASPER system in the MDS 3.0 NH Final Validation or MDS 3.0 SB Final Validation report categories. They will enter the submission ID and run the report. The requested report

ID	Topic	Question	Answer
			will be a .pdf report and will be located in the user's My Inbox when it has completed running. The QIES Assessment Submission and Processing (ASAP) System MDS 3.0 Provider User's Guide is posted on the QTSO website: https://www.qtso.com under the MDS 3.0 link on the left-side.
20100820-034	L - ASAP	Section 4 page 4 of the MDS 3.0 Provider User's Guide says the Final Validation Reports for Swing Beds will be located in CASPER reports with a folder ID of "SB [Provider Internal Number] VR". What number is the "Provider Internal Number" specifically? Is it equivalent to the Nursing Facility ID (FAC_ID)?	The SB Provider Internal Number referred to in the SB shared folder ID is the MDS 3.0 submission FAC_ID field located in the control section of the MDS 3.0 Data Specifications (position 37 - 52 in the flat file). It is the same fac id used by the Swing Bed providers to identify and submit their SB MDS 2.0 records. For SB MDS 2.0, the fac_id item is submitted in the Header Record in positions 30-45.
20100820-033	L - ASAP	When the Submission Confirmation message is presented after a provider uploads a file, is the Submission ID a unique field that will never be used to identify another submission?	Each submission receives a unique MDS 3.0 Submission ID. No other MDS 3.0 submission file will receive that same Submission ID. Please remember that each facility/provider with records in this submission file will receive their own facility Final Validation Report in their shared VR folder. Each of these facility Final Validation Reports will have the same Submission ID.
20100820-032	L - ASAP	Can Nursing Facility and Swing Bed assessments be included in the same zip file?	Records from multiple states and both NH and SB provider types may be included in the same submission file. The questioner is correct that all submissions are submitted to the same page. The MDS 3.0 Welcome page is the page that all state welcome pages and the NACD SB welcome page link to for MDS 3.0 submissions. Pressing the MDS 3.0 link on this page leads the upload page included by the questioner.
20100720-051	L - ASAP	CMS State Site - Will we be logging into the same location? Will the process/screens change for logging in? Is there any supporting documentation that we can receive? Any specification documentation on the submission process would be greatly appreciated.	The QIES Assessment Submission and Processing (ASAP) System MDS 3.0 Provider User's Guide is available on the QTSO website: www.qtso.com. This guide provides detailed information on the submission process, including screen shots of the MDS 3.0 Submission Page.
20100720-049	L - ASAP	Corporate Vendor Account - Will anything change with this account? Will the current ID and password still be valid or will we require a new account?	Your current user ID and password will still be valid for MDS 3.0 submissions.
20100720-045	L - ASAP	Might it be possible for CMS to provide a copy of the HTML that will be used for the login, submission, and validation web pages so we can at least see the new process flow and HTML object names?	There is not an HTML page that can be given out. The system uses Java applications (not plain HTML pages) to generate JSP pages.

ID	Topic	Question	Answer
20100720-044	L - ASAP	Will it be a problem for our facilities to have Windows 7 Operating Systems and use IE 8 to submit the MDS 3.0 EDS files to CMS?	CMS currently does not support Windows 7 or IE 8 for MDS file transmissions. The submission system does not contain any technology that is browser dependent so users should not have any problems if they try to submit with a Windows 7 or IE8 combination; however, if a user has issues while submitting under Windows 7/IE 8, support will not be provided by CMS. Many of the state entities have started converting machines to Windows 7 and IE 8 and they have reported software problems with other software (MDS 2.0 DMS, ASPEN).
20100720-043	L - ASAP	Can you tell me if you will support IE8 using IE7 compatibility mode?	CMS has not done much testing with IE 8 and will not support it at this point. If you upgrade to IE 8 and use the IE 7 compatibility mode, CMS' position for now is use at your own risk.
20100720-038	L - ASAP	Can you tell me if there are any upgrade/enhancements to the applications that will be implemented along with the new MDS 3.0 submission process?	MDS 3.0 is a totally new and separate system from MDS 2.0 so it has all new manuals and documentation. These new user manuals were posted in August with the August downtime. The current MDS 2.0 user manuals are correct for the MDS 2.0 system. We have already updated and posted the revised MDS 2.0 error message manual to include the new fatal error message -408 Invalid Target Date: The target date of this assessment is equal to or greater than 10/01/2010 and may not be submitted to the MDS 2.0 system. This was the only change to the MDS 2.0 system.
20100420-Ad Hoc15	L - ASAP	We have heard in previous calls that validation feedback for MDS 3.0 submissions will only be provided in PDF format with no plans to provide alternatives. PDF format is notorious for being difficult to extract underlying content so providers are facing a real risk of losing the ability to process validation reports in bulk, which can be done with the more accessible ASCII text base formats of the MDS 2.0. When will sample validation reports be available to assess this risk and the viability of extracting the content? What conditions precludes validation feedback in xml or some other machine-interpretable content as a supplement to the human-readable PDF?	The automatically generated Facility Final Validation Report is a text file.
20100420-Ad Hoc14	L - ASAP	How will validation reports for multi-state, multi- facility submissions be delivered to the constituent providers?	If a submission comes in with 10 records for four providers, each of the four providers will receive their own Facility Final Validation report with their own records; they will not receive any information about data submitted for another provider/facility. The validation reports will be automatically

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			generated and inserted into each facility shared VR folder in CASPER at the time the submission is processed. If the submitter (individual who logged in) needs a complete report, a Submitter Validation report will be available, containing all records in the submission for that individual submitter. The Submitter Validation report will only be available to the user who did the submission (log-in id used to submit the file) —not to other individuals in the facilities/providers.
20100420-Ad Hoc13	L - ASAP	If you go to the state welcome page to submit the file, there is an option for MDS 2.0 or 3.0. If you are doing multiple states, does it matter which state welcome page you go to submit the file?	It matters for MDS 2.0, but not for MDS 3.0.
20100420-31	L - ASAP	What are all the communication channels (i.e., FTP or others) in which you will receive MDS 3.0 files in the ZIP format?	We will only receive MDS 3.0 file in the .zip format over the existing CMSNet secure network through the link on each states server 'Welcome' page.
20100420-24	L - ASAP	What will CMS do with the MDS data if an element exceeds the maximum allowed (as specified in itm_mstr)?	A fatal error will be issued and the record will be rejected.
20100225-092	L - ASAP	Will centers still access the existing state IP addresses to submit the MDS 3.0 and 2.0 assessments? Or will a different website or sites be used?	The state welcome page has a new link for submitting MDS 3.0 records added to the page with the current links for submitting MDS 2.0 records and obtaining CASPER reports.
20100225-060	L - ASAP	The application allows a user to enter a partial date for a resident's birth date (A0900). When calculating the age for a resident, the CMS specs state that if the if only the year is entered, then the month and day should be defaulted to '07/02' and if only the year and month are entered, the day should be defaulted to 15. Edit ID 3573 states that the birth date should not be later than all other dates in the system. If a partial date is entered for the birth date, should it be defaulted to the same values in Edit 3778 before comparing it to other dates in the system?	If a partial birth date is submitted, the submission system defaults the missing data prior to any date comparison or calculation of age.
20100225-058	L - ASAP	For a particular ISC there are required fields. If an XML assessment has required fields missing what type of error is thrown? Is it an edit, or is it another type of error?	Missing fields required to identify the facility such as state code, fac_id, type of provider (A0200), type of record will receive specific edit error numbers. Missing clinical fields will receive a different error number. In each case the missing field will be identified in the error information.
20100225-057	L - ASAP	In MDS 2.0 there were fatal file errors. Other than the zip files, xml assessment data, and the max file size limitations, will there be any other fatal file errors (or file edits)?	The MDS 3.0 submission system defers some file editing to after the file has been submitted. There are only three (3) fatal file errors that will be returned immediately upon submission. These three errors are 1- the file size limitation has been exceeded; 2- the file path entered is

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			invalid (no file/path); and 3- an internal submission system error has occurred (system problem). The ASAP system will be updated to not allow upload of any files without the extension of ".zip". All other errors are generated after file acceptance when the file is processed. Errors similar to the MDS 2.0 fatal file errors that may occur on the submitted "zip file" after submission and acceptance of the file are unable to unzip the file and no files contained in zip file. Errors that will occur at the individual "XML: file are: file is not well-formed XML; unable to determine what facility this file belongs to due to missing/invalid field; user is not authorized to submit for this facility; no authorization to collect information (invalid subreq);invalid test/production flag; invalid ISC. There may be other errors added as the system is completed.
20100225-055	L - ASAP	What resident matching algorithm will be used?	The same resident matching algorithm as is used for MDS 2.0, OASIS, MDS Swing Bed 2.0, and IRF-PAI assessment collection.
20100225-017	L - ASAP	Colorado does not allow for the processing and/or storage of STD/HIV data - this is currently blocked by a setting in the DMS - we have the DMS validation set to not process HIV and to not process STD. There are configurable ICD-9 options, too	As in MDS 2.0, states will have the capability to set state specific options in the MDS 3.0 DMS (Data Management System) tool. For MDS 3.0, states will need to access the MDS 3.0 DMS tool prior to October 1, 2010, to set their preferences. These preferences include the flags that govern the collection of STD and HIV data. Each state prohibiting collection of STD and/or HIV data will need to set their Process HIV and/or Process STD flags to "No" (do not process). The state also must enter their state's prohibited diagnose codes on the Prohibited ICD-9 page. The QIES ASAP system will check the STD and HIV collection flags. If the Process HIV and/or Process STD flag(s) for the state is set to "No", then the submission system will remove any diagnosis code in the submitted assessment XML file that matches a prohibited diagnosis code listed in the state's prohibited ICD table. This is the same process as in MDS 2.0. State personnel should note that if they set the Process HIV or Process STD flag to "No", but fail to specify any prohibited diagnosis codes in the prohibited ICD list, then no diagnoses will be removed.
20101101-032	L –	How can a submitter find out if the submission has completed	The MDS 3.0 File Submission system allows the submitted

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	ASAP	processing and the validation report created?	to query and view the status of submission files the submitter successfully uploaded to the National Submission Database. Section 3 of the MDS 3.0 Providers User's Guide pages 3-27 through 3-29 under the header SUBMISSION STATUS describes this functionality. The User's Guide is located on www.QTSO.com under MDS 3.0.
20101101-031	L – ASAP	A nursing home is getting an MDS formatting error -3591 in I8000 for the value ^^^36.10. My initial guess is that the ASAP system is expecting a leading zero if there are only two digits before the decimal (^^036.10) but I want to check with you to see if that is correct or if there is another reason that ^^^36.10 is an incorrect format.	I1800 asks for other diagnosis codes. ICD codes with only 2 digits prior to the decimal point are procedure codes not diagnosis codes. 36.10 is not a valid diagnosis code. Either this is a procedure code which is not submitted in I1800 or it is an incorrect diagnosis code. A correct diagnosis code similar to this is 036.10 (submit as ^^036.10); however, that is not the value sent in to the ASAP system. The value sent failed the edit.
20101101-030	L – ASAP	BIMS Background: BIMS Edit -3660b) If all of the BIMS component items are active and have numeric values AND if four or more of the BIMS component items are equal to 0 (which they are), then C0500 must equal the sum of the values of the component items OR it must equal 99. Question: Can you please advise us on how software vendors are to determine which score it should equal since it can be either 99, or the sum of the fields? This would force users to hand score the BIMS.	Each of the BIMS component items can have a score of zero for either of two reasons: 1) because the resident responded with an incorrect answer, or 2) because they answered with a nonsensical answer or refused to answer at all. If four or more of the items are equal to zero because of reason #1 (the resident gave incorrect answers), then C0500 should contain the simple sum of the items. If four of more of the items are equal to zero because of reason #2 (because of nonsensical answers and/or refusal), then C0500 should contain "99". MDS software cannot distinguish these two cases from the pattern of responses. Similarly, the ASAP system cannot determine this either, which is why Edit -3660 is written so that the summary score in C0500 may contain either the sum of the responses or a "99" if four or more of the component items are equal to zero. The best solution for software developers is probably to provide the user with the calculated sum, but to allow them to override this with a "99" (if four or more of the responses are equal to zero). Only the interviewer will be able to determine whether the sum or the "99" is the correct response.
20101101-029	L – ASAP	We have started receiving Final Validation Reports but are getting all of our MDS assessments rejected with a fatal error stating that the Z0500B date must be in year, month, date format. This is NOT what is listed on the MDS. What should	The printable item subsets and the defined items are have the dates in the format mm/dd/yyyy. The MDS 3.0 Data Specifications require that the dates

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		we do?	must be formatted in the XML file as yyyymmdd. The provider's vendor software should be converting the dates to the required format prior to creating the XML submission file. Please contact the vendor as it is a vendor issue.
20100926-046	L – ASAP	What happens when extra items (XML tags) are sent in the XML submission file?	Extra items that are sent in an XML file but are not active on that ISC will be ignored. They are not edited, not stored, and will not be in the state assessment extract file for that record. No errors messages are sent about any ignored field.
20101101-034	M - Browser	Providers have been prevented from uploading their MDS 3.0 files. Instead of a successful upload, they are receiving the following message: "Upload file name is not in the correct format. Browse for the file and upload again." The users are using IE 7 and their TLS 1.0 is on.	To correct the issue, IE settings should be changed as follows: Select Tools->Internet Options Select the Security tab Select Custom Level... button Locate the setting for "Include local directory path when uploading files to the server" The Disable option will cause a problem, so it should be enabled.